

## GROUP ENROLLMENT FORM FOR GROUP VISION CARE INSURANCE

### Opticare of Utah

1901 West Parkway Blvd., Salt Lake, City, UT 84119  
800-363-0950 (www.opticareofutah.com)

**The Certificate Provides Vision Coverage Only.**

Please print all answers.

<b>1. Employee</b>		
Employee Name (First/Middle/Last):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (Mo./Day/Yr):	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Social Security Number
Home Address (Street, City, State, Zip Code):	Home Phone Number	E-mail Address: (optional)
Name of Employer:	Group Number:	Effective Date:

<b>2. Dependents</b> (Indicate the names of all dependents to be insured under the policy.)			
<b>Name</b>	<b>Date of Birth</b>	<b>Name</b>	<b>Date of Birth</b>
Spouse:		Child:	
Child:		Child:	
Child:		Child:	

<b>3. Benefit Selection</b>	
<b>Vision Plan Selected</b>	

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my vision insurance coverage, if required, purchased through *Opticare of Utah*. I understand that my enrollment under the group policy is for a 12-month period and that premiums must be paid for my enrollment for the entire 12-month period, except due to your: (1) termination of employment with the employer; (2) death; (3) divorce; or (4) election to disenroll during the employer's open enrollment period. This authorization and assignment will remain in effect until revoked by me in writing to my Employer.

I have received, read and understand the outline of coverage for the vision benefit plan I have selected for coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date signed