SPECTERA
A UnitedHealth Group Company

Effective Date: ____/_____/_____
Client Code: **2830** G/L Account: **207531**

**Complete & mail this vision plan enrollment form to:**
**Preferred Benefits LLC**
**21 Theatre Square, Suite 200 Louisville, KY 40202**
**Deductions will be taken out on the second pay period.**

Organization Name: Commonwealth of Kentucky Spectera One

**Payroll Officer Name and Fax Number** _____

## I. Check the Appropriate Boxes

**Coverage Desired**

- ☐ Employee Only $7.27
- ☐ Employee + Spouse $14.44
- ☐ Employee + Child(ren) $15.15
- ☐ Employee + Family $21.61

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA

**REASON FOR CHANGE IN STATUS**

- ☐ Term Coverage
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child*
- ☐ Legal custody of parent*
- ☐ Dependent child married/reached age limit

## II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____ ☐M / ☐F

Your Name _____
(First) (Middle Initial) (Last)

Birth Date _____/ _____/ _____

Address _____

_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

## III. List All Eligible Family Members Below (if electing dependent coverage):

| | First Name | Last Name | Birth Date | Full Time Student? | Sex |
|---|---|---|---|---|---|
| Spouse | | | ____/____/____ | not applicable | ☐M / ☐F |
| Child | | | ____/____/____ | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | | ____/____/____ | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | | ____/____/____ | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | | ____/____/____ | ☐ Yes ☐ No | ☐M / ☐F |

*I agree to continue enrollment in the vision plan for a period of 12 months*

*Your Signature*_____ *Date*_____

Spectera, Inc. administers vision benefits underwritten by the following entities: United HealthCare Insurance Company, United HealthCare Insurance Company of New York, Unimerica Insurance Co., Inc., and American General Assurance Company.