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FOR INTERNAL USE ONLY
HIOS ID# _____
EC _____

Commercial Group Vision Insurance Application/Change Form



CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 3.

Section 1: Employer Group & Benefit Information - To be completed with your Group Administrator

Employer Name _____		Association/Chamber Name (if applicable) _____		Check Desired Action <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
Group Administrator's Signature (required) _____		Date _____	Employee Number _____	Department Number _____	
Vision Information If enrolling in a Vision plan, who do you need coverage for? <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren) <input type="checkbox"/> Self & Spouse, or Self & Domestic Partner <input type="checkbox"/> Family _____ / _____ / _____ Vision Effective Date		Subscriber Status: <input type="checkbox"/> Actively Working <input type="checkbox"/> Retired <input type="checkbox"/> Disability <input type="checkbox"/> Canceled <input type="checkbox"/> COBRA		Vision Plan Selection 	
Vision Group Number _____		Vision Subgroup Number _____		Vision Class _____	

Section 2: Subscriber's Information

Last Name _____		Birthdate: _____ / _____ / _____	
First Name _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender X	
Middle Initial _____	Title (e.g., Jr, Sr, III, etc.) _____		
Street Address _____		Social Security Number _____	
City _____		Date of Hire/Rehire: _____ / _____ / _____	
State _____		Retirement Date: _____ / _____ / _____	
Zip Code _____	Phone _____		
<div style="border: 1px solid black; padding: 5px;"> You must fill out the following section: Would you like to be added to the Donate Life Registry? <input type="checkbox"/> Yes <input type="checkbox"/> Skip this question </div>			

Section 3: Reason for enrollment or change - To be completed by the Group Administrator - Not required for cancellations

Enrollment Opportunity: New Hire Rehire Open Enrollment

Special Enrollment Opportunity: Change in employment status Involuntary loss of coverage Newly Eligible Dependent: Newborn Marriage Other _____
 A move in or out of the service area Former dependent regains eligibility

COBRA Election - Please indicate the reason for COBRA if applicable:
 Left Employment/Retired Disability Divorce/Legal Separation Dependent Reached Max Age Loss of Dependent Status Other: _____ Death of Employee

Demographic Change: Address Birthdate Subscriber Name Dependent Name

Date of Event ____ / ____ / ____

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber

Cancel Code:	Vision Cancel Date:
	/ /

Coverage ends at 11:59 p.m. on the date you indicate

Cancel Codes:

SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*
 SB06-Subscriber No Longer Wants Coverage* (subscriber request)
 SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

* = Not eligible for COBRA

Dependent(s)

Dependent Name:	Cancel Code:	Vision Cancel Date:
		/ /
		/ /
		/ /

Coverage ends at 11:59 p.m. on the date you indicate

Cancel Codes:

M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
 M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
 M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

Spouse Domestic Partner Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

 Last Name (if different) Title First Name MI Social Security Number

Gender:
 Female Male Gender X Birthdate ____/____/____

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

 Last Name (if different) Title First Name MI Social Security Number

Gender:
 Female Male Gender X Birthdate ____/____/____

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

 Last Name (if different) Title First Name MI Social Security Number

Gender:
 Female Male Gender X Birthdate ____/____/____

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

 Last Name (if different) Title First Name MI Social Security Number

Gender:
 Female Male Gender X Birthdate ____/____/____

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

 Last Name (if different) Title First Name MI Social Security Number

Gender:
 Female Male Gender X Birthdate ____/____/____

Note: Use an additional application or addendum if more than five dependents need coverage

Section 6: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents). I hereby accept responsibility for payment of any portion of the premium. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

PREFERRED PROVIDER ORGANIZATION (PPO) I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of vision providers who participate with the PPO and out-of-network benefit that provides coverage for services of vision providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan. I have thoroughly read, understand and agree to comply with the terms of the release in this section

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____

Instructions for completing the Group Vision Insurance Application

Section 1: Employer Group & Benefit Information - This section should be completed with your Group Administrator. Group Administrator's signature is required. Group numbers and information must be populated. Select who you need coverage for on the vision plan and indicate the subscriber's status. Next, select the vision plan you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information - To be completed by the Subscriber.

Health Equity: Health care should meet the needs of everyone—no matter who you are, where you live, or who you love. To learn more about health equity and view our privacy policy, visit UniveraHealthcare.com/HealthEquity.

Donate Life Registry: By checking "Yes" and signing this application, you are consenting to enroll in the New York State Donate Life Registry (Registry). To modify your gift or withdraw from the Registry go to: donatelife.ny.gov or call the Registry at 1-866-NY-DONOR.

Section 3: Reason for enrollment or change - Select the box(es) that describe(s) the reason for this enrollment or change regarding vision insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within [30; 60] days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for? - If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information) - Please include information about all the people who you would like coverage for.

Qualified guidelines for coverage include: (a) A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk). (b) Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren). (c) Qualified dependents and students are covered through the end of the month in which they turn 26 years of age. (d) There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

Section 6: Release - Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

Please return to: P.O. Box 211256 Eagan, MN 55121-2656

If you have questions, please contact your Group Administrator. Or, visit us at: UniveraHealthcare.com