

**UNITED HEALTHCARE INSURANCE COMPANY**

A Stock Company

450 Columbus Boulevard, Hartford, Connecticut

Phone: 1-860-702-5000

**APPLICATION FOR VISION CARE INSURANCE**

The undersigned Applicant requests the Vision Care Insurance Benefits shown herein and provided by United Healthcare Insurance Company, and agrees to be bound by the terms and provisions of the Vision Care Insurance Policy.

**Full Legal Name of Applicant:** \_\_\_\_\_  
**Address:** (street, city, state, and zip) \_\_\_\_\_  
**Contact Person:** \_\_\_\_\_  
**Telephone No.:** \_\_\_\_\_  
**Tax ID:** \_\_\_\_\_

**Fax No.:** \_\_\_\_\_

**Total number of eligible persons:** \_\_\_\_\_ **Total number of covered persons:** \_\_\_\_\_

**Requested Effective Date:** From: \_\_\_\_\_ To: \_\_\_\_\_

**PARTICIPATION:**

- Non-contributory (all persons covered)
- Contributory: Applicant Contribution: \$\_\_\_\_\_ Employee; \$\_\_\_\_\_ Employee + Spouse;  
\$\_\_\_\_\_ Employee + One; \$\_\_\_\_\_ Employee + Children;  
\$\_\_\_\_\_ Family; \$\_\_\_\_\_ Composite

**BENEFIT DESIGN:**

**Network Benefits:**

Frequency of Services: Vision Exam: \_\_\_\_\_ Months  
Lenses: \_\_\_\_\_ Months  
Frames: \_\_\_\_\_ Months

Co-Payments: \$\_\_\_\_\_ At time of Service; OR  
\$\_\_\_\_\_ Toward Examination  
\$\_\_\_\_\_ Toward Materials (lenses and /or frame)

Non-Selection Contact Lenses: \$\_\_\_\_\_ Allowance; every \_\_\_\_\_ Months

**Out-of-Network Benefits:**

Vision Exam:	<b>\$40.00</b>	Lenticular Lenses:	<b>\$80.00</b>
Single Lenses:	<b>\$40.00</b>	Frame:	<b>\$45.00</b>
Bifocal Lenses:	<b>\$60.00</b>	Elective Contact Lenses:	<b>\$105.00</b>
Trifocal Lenses:	<b>\$80.00</b>	Medically Necessary Contact Lenses:	<b>\$210.00</b>

**ELIGIBILITY INFORMATION:**

**Employee Waiting Period Options**

- First of the month following \_\_\_\_\_ days of employment
- Other: \_\_\_\_\_

To be eligible, Employee must work \_\_\_\_\_ or more hours per week, and must be actively at work on the effective date of insurance. If not actively at work, insurance will be effective on the first day of the month following return to active employment

**Dependent Age Requirements:** Birth to \_\_\_\_\_ or \_\_\_\_\_ if full-time student

**Dependent Termination:**  Date Dependent attains age limit;  End of calendar year Dependent attains age limit; or  Other: \_\_\_\_\_

College verification required?  Yes  No

**PREMIUMS:**

All premiums are due on the first day of the calendar month of insurance.

**Initial Premium:** Amount Due \$ \_\_\_\_\_ Amount Received \$ \_\_\_\_\_

**Premium Rates:**

**Prepaid Plan:**

Employee Only:	\$ _____	Number covered: _____	= \$ _____
Employee + One:	\$ _____	Number covered: _____	= \$ _____
Employee + Spouse:	\$ _____	Number covered: _____	= \$ _____
Employee + Children:	\$ _____	Number covered: _____	= \$ _____
Employee + Family:	\$ _____	Number covered: _____	= \$ _____
Composite:	\$ _____	Number covered: _____	= \$ _____
			<b>TOTAL MONTHLY PREMIUM:</b> = \$ _____

**It is understood and agreed that the Vision Care Insurance will become effective on the date requested only if this Application is accepted. The Applicant agrees to transmit the total premiums for this insurance to United Healthcare Insurance Company when due. The Applicant declares to the best of its knowledge and belief that statements and answers on this Application are complete and true.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_.

Full Legal Name of Applicant: \_\_\_\_\_  
Signature of Authorized Person: \_\_\_\_\_  
Print Name: \_\_\_\_\_

Name of Agent or Broker: \_\_\_\_\_  
Signature of Agent or Broker: \_\_\_\_\_  
Print Name: \_\_\_\_\_

Agent Address: \_\_\_\_\_  
Agent's Telephone No.: \_\_\_\_\_ Agent's Fax No.: \_\_\_\_\_ License No.: \_\_\_\_\_

Send completed Application to **Spectera, Inc.**  
**1225 North Loop West, Suite 900**  
**Houston, TX 77008**

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For applicants in Arkansas and Louisiana:**  
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, is guilty of a crime and may be subject to fines and confinement in prison.

**For applicants in Colorado:**  
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

**For applicants in District of Columbia:**  
**WARNING:** It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

**For applicants in Florida:**  
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:**

**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 subjects such person to criminal and civil penalties.**

**For applicants in Maine, Tennessee and Virginia:**

**It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.**

**For applicants in New Jersey:**

**Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

**For applicants in all other states:**

**It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.**