UnitedHealthcare®
Specialty Benefits℠
UnitedHealthcare Vision℠

Enrollment Form

TO BE COMPLETED BY BENEFITS OFFICE:
Effective Date: _____/_____/_____
Client Code: **GMXC** Sub Code:___
G/L Number: **0713694**

Organization Name: **AXIOM RESOURCES MANAGEMENT, INC.**

I. Check the Appropriate Boxes

Coverage Desired

- ☐ Employee Only
- ☐ Employee + One
- ☐ Employee + Family

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

REASON FOR CHANGE IN STATUS

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ 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 _____ - _____ - _____

Date of Hire _____ - _____ - _____ Gender

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

*Signature*_____ *Date*_____