



**Vision Plan Application  
University of Wisconsin System**

**Section I**

Employee/Applicant Name (Last, First, Middle Int.)	Birth Date (MM/DD/YY)	Social Security Number	
Address (Street, City, State, Zip Code)		Home Phone	Work Phone

**Section II**

**Reason for Submitting Application (Check the appropriate reason):**

- Initial Enrollment** (Complete all sections)
- Open Enrollment** (Complete all sections)
- Change of Name or Address** – (Complete Section V only)
- Adding a Dependent** – (List in Section IV the dependent(s) being added)
  - Birth                       Adoption                       Domestic Partnership
  - Student Status               Marriage                       Legal Custody of Parent
- Deleting Dependent** – (List in Section IV the dependent(s) being deleted)
  - No Longer Student               Dependent married               Dependent reached age limit
  - Divorce                       Death                       Domestic Partnership Termination
- Canceling Coverage (Note, cancellation is effective at the end of the year in which the cancellation form is submitted.)** – (Complete Section V only)
- Termination or Retirement** – (Complete Section V only)
- Waiver** – (Complete Section V only)

**Section III**

**Coverage Desired:**

- Employee/Applicant Only
- Employee + Spouse/Domestic Partner
- Employee/Applicant + Child(ren)
- Employee/Applicant + Family

**Section IV: Complete the following information ONLY for individuals covered by the policy**

Last Name	First Name	Birth Date	Gender	Relationship
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

**Section V: Date, sign and submit this form to your Payroll & Benefit office**

*I agree to continue enrollment in the vision plan for a period of 12 months and I understand that I must submit an application by December 1<sup>st</sup> to cancel the plan effective December 31<sup>st</sup>, or my coverage will automatically be extended for the following plan year.*

<b>Date (Mo/Day/Yr)</b>	<b>Signature:</b>
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For Office Use Only:

Date Received by Employer	Received by:	Hire Date (Mo/Day/Yr)	Coverage Effective or Paid Thru date	Premium	Deduction Code	Processor Initials	Group Number
				\$	410		F4ZL

**OptumHealth/Employer/Employee**