Universal Enrollment/Change Form

☐ Annual Enrollment ☐ New Enrollment ☐ Late Enrollment (Statement of Health Required for Late Entrants)	❑ BENEFICIARY CHANGE ❑ COVERAGE CHANGE REASON:	❑ ADD DEPENDENT ❑ DROP DEPENDENT REASON:	❑ COBRA ❑ OTHER SPECIFY:

Employer Information:

Employer Name ***AERO Special Education School District***				
Address: **7600 South Mason**		City: **Burbank**	State **IL**	Zip: **60459**
Group Number: **M001163**	Division:	Class:	Date of Hire:	Coverage Effective Date:

Employee Information:

Last Name	First Name	M.I.	Marital Status ❑ Single ❑ Divorced ❑ Married ❑ Widowed
Social Security Number	Date of Birth	Gender ❑ Male ❑ Female	Number of Hours per Week: _______
Residence Mailing Address (Number, Street, Apartment)	City	State	Zip
Home Telephone ( )	Salary: $_____________________ ❑ Hourly ❑ Weekly ❑ Monthly❑ Annual	Occupation/Job Title:	

Dependent Information vision coverage: *(Dependent information must be completed if choosing coverage for dependents.)*

FIRST NAME	LAST NAME	RELATIONSHIP DAUGHTER (D) OR SON (S)	SEX		DATE OF BIRTH (MM-DD-YY)	SOCIAL SECURITY NUMBER	Are you selecting vision coverage for this dependent?
			M	F			
		Spouse					

Vision Benefit Elections (Please choose one option.)

Voluntary Vision – Spectera Vision (Confident)
- ❑ Employee Only ($3.53 Bi-Weekly)
- ❑ Employee & Spouse ($6.69)
- ❑ Employee & Child(ren) ($7.03)
- ❑ Employee & Spouse & Child(ren) ($10.81)
- ❑ I decline Voluntary Vision

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.

Signature Section:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in Spouse & Child(ren) status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

X

____

Employee Signature Date