UnitedHealthcare®

Vision Enrollment Form

Dade County Firefighters Insurance Trust

SOCIAL SECURITY NUMBER	Retiree / Widow	❑ Enroll ❑ Cancel ❑ Change ❑ Address Change ❑ Number Change Date of Change / /	
LAST NAME	FIRST NAME	MI	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
TELEPHONE NIMBER Cell ( )	Home ( )	❑ Male ❑ Female ❑ Single ❑ Married	
PLAN COVERAGE	❑ Retiree Only	❑ Retiree Plus 1 Dependent	❑ Retiree Plus 2 or More Dependents
Annual Premium	$ 65.00	$ 128.00	$ 212.00

INFORMATION FOR DEPENDENT COVERAGE

Last Name	First Name	MI	Relationship**	Date of Birth	Social Security Number
			❑ Wife ❑ Husband		
			❑ Son ❑ Daughter		
			❑ Son ❑ Daughter		
			❑ Son ❑ Daughter		
			❑ Son ❑ Daughter		

EMPLOYER INFORMATION - TO BE FILLED OUT BY EMPLOYER

COMPANY NAME: Dade County Firefighters Insurance Trust			ENROLLEE EFFECTIVE DATE: (Mo/Day/Yr ____/____/____	
ENROLLMENT: ❑ Retirement ❑ Other	DATE OF RETIREMENT: (Mo/Day/Yr) ____/____/____	POLICY NUMBER:	PLAN CARIATION/REPORTING CODE:	PLAN CODE:

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.

I wish to enroll in the plan indicated above as offered by Dade County Firefighters Insurance Trust. I understand that this is a minimum one (1) year commitment. I hereby authorize deduction of the applicable bi-weekly amount from my salary for coverage of optional benefits for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me herein is true and complete to the best of my knowledge.

SIGNATURE:_____ DATE: _____