UnitedHealthcare®

Vision Enrollment Form

Dade County Firefighters Insurance Trust

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER	❑ Enroll ❑ Cancel ❑ Change ❑ Address Change ❑ Number Change Date of Change / /
LAST NAME	FIRST NAME / MI	ENROLLEE'S DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP	
TELEPHONE NIMBER Cell ( ) Work ( )		❑ Male ❑ Female ❑ Single ❑ Married
PLAN COVERAGE	❑ **Employee Only**	❑ **Employee Plus 1 Dependent** ❑ **Employee Plus 2 or More Dependent**
Biweekly Premium	$ 2.47	$ 4.93 $ 8.16

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 _____/_____/ _____	CLASS CODE: **ACTIVE**
ENROLLMENT: ❑ New Hire ❑ Other	DATE OF HIRE: (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: _____