TRANSAMERICA
WORKSITE MARKETING

Underwritten by Transamerica Assurance Company
Home Office: Kansas City MO

SightSelect℠ Vision Care Insurance Enrollment Form

Organization Name: _____

I. Check the Appropriate Boxes

Coverage Desired

- ☐ Employee Only $_____
- ☐ Employee + Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee + Family $_____
- ☐ Employee + One $_____

- ☐ New Enrollment
- ☐ Change of Status
- ☐ Open Enrollment
- ☐ COBRA

REASON FOR CHANGE IN STATUS

- ☐ Termination/Cancel Coverage
- ☐ Address Change(new address)
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Divorce
- ☐ Death
- ☐ Last Name
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent
- ☐ Dependent child married/ reached age limit
- ☐ Add or Delete Dependent

Effective Date ____/____/____

II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____ Birth Date _____/_____/_____

Your Name _____
(First) (Middle Initial) (Last)

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

*Your Signature*_____ *Date*_____

WMD 6230-0203

Mail or fax this form to:

Spectera Inc
2811 Lord Baltimore Dr
Baltimore MD 21244-2644
Tel: (800) 638-3895
Fax: (410) 265-6049

Note: Changes must be received by the 15th of the month to be reflected on your next invoice.