



# UCC Vision Benefits Plan Enrollment Application

Employer ID: \_\_\_\_\_

Member ID: \_\_\_\_\_

## EMPLOYEE PERSONAL INFORMATION

Name of Member (last name, first name): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

**Vision Plan premiums are payable in one annual payment.** Please send your payment along with this completed application, postmarked no later than March 20, 2023.

**Please mail your completed application along with your payment to:  
The Pension Boards-UCC, 75 Remittance Drive, Suite 1592, Chicago, IL 60675-1592.**

I hereby enroll in the UCC Vision Benefits Plan option selected below:

Single Adult	<input type="checkbox"/> \$110.00	One Adult with Child(ren)	<input type="checkbox"/> \$180.40
Two Adults	<input type="checkbox"/> \$201.30	Two Adults with Child(ren)	<input type="checkbox"/> \$273.90

## DEPENDENT INFORMATION - List any dependents that should have coverage.

Name	Relationship to Participant	Date of Birth	Social Security Number	Gender
		/ /		
		/ /		
		/ /		

## MEMBER CONSENT

Employee Name: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

## EMPLOYER VERIFICATION

By signing this form, the Employer, by its duly authorized officer or other representative, hereby agrees to the provisions, rules, and procedures with respect to eligibility and contributions as indicated on this application, and in alignment with the Employer Adoption Agreement.

Employer Name: \_\_\_\_\_

Signature of authorized officer: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_