



Columbia, MD

TO BE COMPLETED BY BENEFITS OFFICE:	
Effective Date:	_____ / _____ / _____
Client Code:	_____ Sub Code _____
G/L Number:	_____

Vision Plan Enrollment Form

Organization Name: Illinois Municipal Retirement Fund

I. Check the Appropriate Boxes					
Coverage Desired <input type="checkbox"/> Employee Only \$7.50 <input type="checkbox"/> Employee + One \$13.25 <input type="checkbox"/> Employee + Family \$21.70		<input checked="" type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Status/Address <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA		REASON FOR CHANGE IN STATUS <input type="checkbox"/> Termination <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn Child <input type="checkbox"/> Other Insurance <input type="checkbox"/> Move to COBRA <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Last Name/Address Change <input type="checkbox"/> Adoption/legal custody of child <input type="checkbox"/> Legal custody of parent <input type="checkbox"/> Dependent child married/reached age limit	
II. Employee Information (please print clearly):					
Unique Member ID Number (SSN) _____ - _____ - _____					
Your Name _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> (First) (Middle Initial) (Last) </div>					
Birth Date ____ / ____ / ____					
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	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____ / ____ / ____	<input type="checkbox"/> Yes • <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____ / ____ / ____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 months

Your Signature _____ Date _____

Please return to:
 Doyle Rowe LTD
 105 South York Rd., Suite 230
 Elmhurst, IL 60126
 1-800-564-7227

Spectera, Inc. administers vision benefits **underwritten** by the following entities: United HealthCare Insurance Company, United HealthCare Insurance Company of New York, Unimerica Insurance Co., Inc., and American General Assurance Company.

TO BE COMPLETED BY ADMINISTRATOR

PLAN NAME!	PLAN CODE	MEMBER	PLAN CODE	SPOUSE	COVERAGE EFFECTIVE
PacificCare Seniors Choice					
Blue Cross Blue Shield of Illinois					
Blue Cross Blue Shield of Texas					
Health Care Alliance					
Mercy Health Plan Premier Plus					
Humana Private Fee for Service					
Humana HMO					
Sav-Rx Advantage Card					
Prudential Long Term Care Plan					

	PLAN CODE _____	Member _____	Coverage Effective Date _____
Delta Dental Plan of Illinois	PLAN CODE _____	Spouse _____	Coverage Effective Date _____
	PLAN CODE _____	Family _____	Coverage Effective Date _____

	PLAN CODE _____	Member _____	Coverage Effective Date _____
Spectera Vision Care Plan	PLAN CODE _____	Spouse _____	Coverage Effective Date _____
	PLAN CODE _____	Family _____	Coverage Effective Date _____