

SPECTERA

VISION PLAN ENROLLMENT FORM FOR: AFSCME Local 2076 Health and Welfare Trust

I. Choose Your Level of Coverage (check one):

Employee Only (CODE: _____) Employee + One (CODE: _____) Employee + Family (CODE: _____)
Spectera use only

II. Effective Date (must complete):

____/____/____
(Month) (Day) (Year)

Date of Hire:

____/____/____
(Month) (Day) (Year)

III. Employee Information (please print clearly):

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

D.O.B. ____/____/____ Soc. Sec. # _____ - _____ - _____ Male Female

Address _____
(Street Address)

(City) (State) (Zip)

Home Phone (____) _____ Work Phone (____) _____

IV. List All Eligible Family Members Below (if electing dependent coverage):

<u>First Name</u>	<u>Last Name</u>	<u>Date of Birth</u>	<u>Full-Time Student?</u>
Spouse _____	_____	____/____/____	not applicable
Child _____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child _____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child _____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child _____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Your Signature: _____

Date ____/____/____

Spectera, Inc.
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