MACOMB INTERMEDIATE SCHOOL DISTRICT
VISION ENROLLMENT/CHANGE IN STATUS FORM
UNITED HEALTH CARE POLICY #755152

General Information Employee

Name (Last) (First) MI Social Security # Gender Birthdate

Address City State Zip Code

Occupation Hire Date

Change In Status

☐ Open enrollment
☐ Marriage/Date __________
☐ Divorce/Date __________
☐ Dependent Add/Delete
☐ Birth/Date ___________
☐ Life Event/Date ___________

Note: Change in Status must be completed within 30 days of the event.

Dependent Information

Name (Last)	First	MI	*Social Security #	Gender	Birthdate	Relationship	Add/Delete
							Add Delete
							Add Delete
							Add Delete
							Add Delete
							Add Delete
							Add Delete

*** Social Security Numbers are required per the Affordable Care Act.**

Is there a court order requiring coverage for any dependent in the case of divorced or legally separated parents? ____Yes _____ No

Note: If enrolling a 19-25yr old dependent, please include full time college status information along with tax dependent information.

Employee Signature ____ Date ___________________________