

UnitedHealthcare Insurance Company Enrollment Form - Vision

2011-470-1



Kansas State University

Send completed application with check made payable to UnitedHealthcare **StudentResources** to:
UnitedHealthcare **StudentResources**, PO Box # 809026, Dallas, Texas 75380-9026.

SOCIAL SECURITY NUMBER		SCHOOL ID NUMBER		<input type="checkbox"/> Enroll	<input type="checkbox"/> Cancel	<input type="checkbox"/> Change
				<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	
		Date of Change ____/____/____				
LAST NAME		FIRST NAME		MI	ENROLLEE'S DATE OF BIRTH	
ADDRESS			CITY	STATE	ZIP	
TELEPHONE NUMBER		Home ()		Work ()		<input type="checkbox"/> Male <input type="checkbox"/> Female
						<input type="checkbox"/> Single <input type="checkbox"/> Married
PLAN PERIOD <input type="checkbox"/> Annual		<input type="checkbox"/> Semi Annual ¹		<input type="checkbox"/> Semi Annual ²		
Enrollment Deadline: 09/14/11		Enrollment Deadline: 09/14/11		Enrollment Deadline: 03/17/12		
Effective and Termination Dates: 08/01/11-07/31/12		Effective and Termination Dates: 08/01/11-01/31/12		Effective and Termination Dates: 02/01/12-07/31/12		
PLAN COVERAGE <input type="checkbox"/> Student <input type="checkbox"/> Student + Spouse (or Domestic Partner*) <input type="checkbox"/> Student + Child(ren) <input type="checkbox"/> Student + Family						

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name	Initial	Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	If child is over age 19, please indicate status and school	
				<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Domestic Partner*	Student at _____	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female

Please send a check or money order for your premium payment, along with your completed and signed enrollment form, to the address indicated. If you would like to use a credit card to enroll, please go to www.uhcsr.com/kbor, select your school, click Enroll Now and follow the instructions.

* Domestic Partner coverage is determined by your Student Health Plan. Please confirm coverage for Domestic Partners with your medical carrier.

** For court ordered dependent, legal documentation must be attached. Please see student representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible subscriber, please provide address on separate sheet.

Annual	Student -	\$97.32	Student + Spouse	\$194.76	Student + Domestic Partner	n/a	Student + Family	\$261.60
Semi Annual	Student -	\$48.66	Student + Spouse	\$97.38	Student + Domestic Partner	n/a	Student + Family	\$130.80

I confirm that the information I have provided on this form is complete and accurate.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE: _____ DATE: _____

UnitedHealthcare Vision insurance products are either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut (except in New York), UnitedHealthcare Insurance Company of New York, Hauppauge, New York (New York only), or United Healthcare Services, Inc.