UnitedHealthcare Insurance Company
Enrollment Form - Vision

2013-2014

UnitedHealthcare® Specialty Benefits™

Kansas State University

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

SOCIAL SECURITY NUMBER	SCHOOL ID NUMBER	❑ Enroll ❑ Cancel ❑ Change ❑ Address Change ❑ Name Change Date of Change ____/____/_____

LAST NAME	FIRST NAME	MI	ENROLLEE'S DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER Home ( ) Work ( )

❑ Male ❑ Female
❑ Single ❑ Married

PLAN PERIOD

❑ Annual Enrollment Deadline: 09/14/2013 Effective and Termination Dates: 07/31/2014

PLAN COVERAGE ❑ Student ❑ Student + Spouse (or Domestic Partner*) ❑ Student + Child(ren) ❑ 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	
		❑ Wife ❑ Husband ❑ Domestic Partner*	Student at _____	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female
		❑ Son ❑ Daughter	Student at _____	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female
		❑ Son ❑ Daughter	Student at _____	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female
		❑ Son ❑ Daughter	Student at _____	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female
		❑ Son ❑ Daughter	Student at _____	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ 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 and select the Enroll Now link to enroll online.

** 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 -	$155.04	Student + Spouse	$310.28	Student + Domestic Partner	$310.28	Student + Family	$416.84

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.