UnitedHealthcare Insurance Company
Enrollment Form - Vision

2014-2015

UnitedHealthcare Specialty Benefits℠

Wright 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: 08/15/14 Effective and Termination Dates: 07/01/14 to 06/30/15			

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/DayNr)	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, and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then 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 and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.