UnitedHealthcare Insurance Company
Enrollment Form - Vision

2014-451-1

UnitedHealthcare® Specialty Benefits℠

University of Chicago

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: 10/16/2014 Effective and Termination Dates: 09/01/2014-08/31/2015		
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/UChicago 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.