UnitedHealthcare Insurance Company
Enrollment Form - Vision

2015-1195-4

UnitedHealthcare® Specialty Benefits℠

UNIVERSITY OF WEST GEORGIA

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

SOCIAL SECURITY NUBER	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: 9/15/15 Effective and Termination Dates: 8/1/15 – 7/31/16

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/usg 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	$118.24	Student + Spouse	$224.22	Student + Domestic Partner	$224.22	Student + Family	$369.84

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.

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