# UnitedHealthcare Insurance Company
# Enrollment Form - Vision

2015-78-1

UnitedHealthcare® Specialty Benefits™

## GEORGIA SOUTHWESTERN 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 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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