

UNIVERSITY OF WEST GEORGIA

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

SOCIAL SECURITY NUMBER		SCHOOL ID NUMBER		<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Date of Change ____ / ____ / ____	
LAST NAME		FIRST NAME		MI	ENROLLEE'S DATE OF BIRTH
ADDRESS			CITY	STATE	ZIP
TELEPHONE NUMBER Home ()		Work ()		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married	
PLAN PERIOD <input type="checkbox"/> Annual Enrollment Deadline: 9/15/16 Effective and Termination Dates: 8/1/16 – 7/31/17					
PLAN COVERAGE <input type="checkbox"/> Student <input type="checkbox"/> Student + Spouse <input type="checkbox"/> Student + Child(ren) <input type="checkbox"/> 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
				<input type="checkbox"/> Wife <input type="checkbox"/> Husband	Student at _____
				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____
				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____
				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____
				<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Male <input type="checkbox"/> 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.

** 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	\$121.20	Student + Child(ren)	\$269.54	Student + Spouse	\$229.83	Student + Family	\$379.09
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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.