

UnitedHealthcare Insurance Company Enrollment Form

UnitedHealthcare Dental*

2016-1291-1

Loyola University Chicago

IMPORTANT: Coverage will not begin until payment is received and processed.
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 ()	
PLAN PERIOD		<input type="checkbox"/> Annual Enrollment Deadline: 09/14/16 Effective and Termination Dates: 08/01/16-07/31/17		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married	
PLAN COVERAGE <input type="checkbox"/> Student <input type="checkbox"/> Student + Spouse (or Civil Union Partner*) <input type="checkbox"/> Student + Child(ren) <input type="checkbox"/> Student + Family					
INFORMATION FOR DEPENDENT COVERAGE Spouse (or Civil Union Partner) & 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 <input type="checkbox"/> Civil Union <input type="checkbox"/> Partner*	Student at _____ _____ <input type="checkbox"/> Handicapped
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____ _____ <input type="checkbox"/> Handicapped
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____ _____ <input type="checkbox"/> Handicapped
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____ _____ <input type="checkbox"/> Handicapped
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Student at _____ _____ <input type="checkbox"/> Handicapped

* Civil Union Partner coverage is determined by your Student Health Plan. Please confirm coverage for Civil Union Partners with your medical carrier.
 ** For court ordered dependent, legal documentation must be attached. Please see school 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	\$350.00	Student + Child(ren)	\$851.50	Student + Spouse (or Civil Union Partner)	\$700.00	Student + Family	\$1,271.35
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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/luc and select the Enroll Now link to enroll online.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that if I and/or my dependents (including my spouse or civil union Partner), if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse or civil union partner) because of other dental coverage, I may in the future be able to enroll myself or my dependents (including my spouse or civil union partner) in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, civil union partnership, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, civil union partnership, birth, adoption, or placement for adoption.

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.

The Certificate provides dental benefits only. Review your Certificate carefully.

SIGNATURE: _____ DATE: _____

UnitedHealthcare Dental 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. UnitedHealthcare Dental Select HMO product is provided or administered by the following UnitedHealth Group companies: Dental Benefit Providers, Inc., Dental Benefit Providers of California, Inc., Dental Benefit Providers of Illinois, Inc., Dental Benefit Providers of Maryland, Inc. and/or Dental Benefit Providers of New Jersey, Inc.