# UnitedHealthcare Insurance Company
# Enrollment Form - Vision

2016-212-1

UnitedHealthcare® Specialty Benefits℠

## Wright 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: 10/12/2016 Effective and Termination Dates: 08/29/2016-08/28/2017

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, and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then 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 | $122.76 | Student + Child(ren) | $273.00 | Student + Spouse | $232.80 | Student + Domestic Partner | $232.80 | Student + Family | $384.00 |
|---|---|---|---|---|---|---|---|---|---|---|

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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