

UnitedHealthcare Insurance Company
Enrollment Form - Vision

2016-284-4



Old Dominion University

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 |
| | | | | <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/odu 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 | \$121.44 | Student + Child(ren) | \$270.12 | Student + Spouse | \$230.28 | Student + Family | \$379.92 |
|--------|---------|----------|----------------------|----------|------------------|----------|------------------|----------|

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.