UnitedHealthcare Insurance Company Enrollment Form - Vision



2016-2017

Kansas 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 SECUR	RITY NUBER	SCHOOL ID NUMBER					☐ Enroll ☐ Ca ☐ Address Change Date of Change			☐ Name Change		
LAST NAME	AST NAME FIRST NAME				MI ENRO			LLEE'S OF BIRTH				
ADDRESS			CI	TY		1	STATE			ZIP		
TELEPHONE NU	JMBER Home	()	<u>'</u>	Work	()				□ Male		emale	
PLAN PERIOD										☐ Single ☐ Married		
□ Annual	Enrollment Deadlin	e: 09/14/20	016 Effe	ective and Ter	rmination D	ates: 08/01/	2016-07/3 ⁻	1/2017				
PLAN COVERAG	GE □ Student	□ Stu	ıdent + Spouse)		□ Stude	ent + Child	(ren)	□ Stude	nt + Family		
INFORMATION FOR DEPENDENT COVERAGE Spouse & Unmarried Dependent Children Only (Include Date of Birth)												
First Name Initi	Relations	ship**	If child is over age 19, please indicate status and school									
				□ Wife □ H	Husband	Student at			□ Enroll	☐ Change	: □ Cancel	
						Otadont at			□ Male	□ Female		
	□Son □Daughter Student at				□ Enroll	☐ Change	□ Cancel					
									☐ Male	☐ Female		
				□Son □ Daug		Student at				☐ Change		
							,		☐ Male	☐ Female		
				□Son □[Daughter	Student at			□ Enroll □ Change □ Cancel			
									☐ Male	□ Female		
				□ Son □ [Daughter	Student at		□ Enroll □ Change □ Cancel				
									□ Male □ Female			
	eck or money order f a credit card to enrol									ddress indic	ated. If you	
** For court or	tner coverage is det dered dependent, l for full-time student	egal docu	mentation mus	st be attach	ed. Pleas	se see stud	ent repre	sentative	e for more	information	about the	
Annual Stud	ent \$123.36	Student +	· Child(ren)	\$274.32	Student +	Student + Spouse		88 8	tudent + Family		\$385.92	
I confirm that the i	information I have pr	ovided on	this form is cor	nplete and a	ccurate.							
Any person who k	knowingly presents a uilty of a crime and n	a false or f	raudulent clain	n for paymen	nt of a loss		r knowing	ly preser	nts false in	formation in	an application	
SIGNATURE:		DATE:										
UnitedHealthcare	Vision insurance pro edHealthcare Insura	oducts are	either underw	ritten or provi	ided by: Ur	nitedHealthc	are Insura	nce Cor	npany, Har	tford, Conne	cticut (except	

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