UnitedHealthcare Insurance Company
Enrollment Form - Vision

2016-566-4

UnitedHealthcare® Specialty Benefits℠

ABRAHAM BALDWIN AGRICULTURAL COLLEGE

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

SOCIAL SECURITY NUMBER	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: 9/15/16 Effective and Termination Dates: 8/1/16 – 7/31/17	

PLAN COVERAGE ☐ Student ☐ Student + Spouse ☐ 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	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/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

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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