UnitedHealthcare Insurance Company
Enrollment Form - Vision

UnitedHealthcare

2017-1193-4

VALDOSTA STATE UNIVERSITY

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		❑ Enroll ❑ Address Change ❑ Name Change Date of Change____/____/____
LAST NAME	FIRST NAME	M I	ENROLLEE'S DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER Home ( )	Work ( )		❑ Male ❑ Female ❑ Single ❑ Married
PLAN PERIOD ❑ Annual Enrollment Deadline: 9/15/17 Effective and Termination Dates: 08/01/17-07/31/18			
PLAN COVERAGE ❑ Student ❑ Spouse ❑ One Child ❑ Two or more Children ❑ Spouse and Two or more Children			

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 ____________ ____________ ❑ Disabled	❑ Enroll ❑ Male ❑ Female ❑ Other Vision Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________ ❑ Disabled	❑ Enroll ❑ Male ❑ Female ❑ Other Vision Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________ ❑ Disabled	❑ Enroll ❑ Male ❑ Female ❑ Other Vision Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________ ❑ Disabled	❑ Enroll ❑ Male ❑ Female ❑ Other Vision Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________ ❑ Disabled	❑ Enroll ❑ Male ❑ Female ❑ Other Vision Insurance ____________ Carrier Name

***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	121.20	Spouse	108.63	One Child	148.34	Two or more Children	148.34	Spouse + Two or more Children	257.89

For Custom URLs use:

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 Explore Policy on the Vision Policy card, then select Enroll Now.

Notice to Student: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on the enrollment card; 2) Rates are not pro-rated other than as listed on the enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

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

I understand that the vision benefit plan I have selected provides reimbursement for certain vision 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 vision provider or me or vision expenses which I have incurred may not be covered by my vision benefit plan.

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 vision benefits only. Review your Certificate carefully.

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. Plan Period provides coverage for the dates indicated and must be enrolled in prior to the indicated deadline date.

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your identification card, Monday through Friday, 7 a.m. to 10 p.m. CST.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-800-638-3120, TTY 711, Monday through Friday, 7 a.m. to 10 p.m. CST.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-800-638-3120.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-800-638-3120。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-638-3120.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-638-3120번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-638-3120.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-800-638-3120.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-800-638-3120.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-638-3120.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement.

Veuillez appeler le 1-800-638-3120.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-638-3120.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-638-3120.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-638-3120.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-638-3120 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-800-638-3120 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-800-638-3120 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-638-3120

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-638-3120.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-800-638-3120។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-638-3120.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-800-638-3120 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-638-3120.