UnitedHealthcare Insurance Company
Enrollment Form - Vision

2018-1457-1

Valparaiso 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	MI	ENROLLEE'S DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER Home ( )	Work ( )		❑ Male ❑ Female ❑ Single ❑ Married
PLAN PERIOD ❑ Annual Enrollment Deadline: 9/14/18 Effective and Termination Dates: 8/1/18 – 7/31/19			
PLAN COVERAGE ❑ Student ❑ Spouse (or Domestic Partner*) ❑ 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 ❑ Domestic Partner*	❑ 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

** 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 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	151.32	Spouse/Domestic Partner	135.60	One Child	185.16	Two or more Children	185.16	Spouse + Two or more Children	321.96

10/05 ©2005 United HealthCare Services, Inc.

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/valpo 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.

©2010 United HealthCare Services, Inc