

UnitedHealthcare Insurance Company Enrollment Form - Vision

2018-1457-4



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		<input type="checkbox"/> Enroll <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: 9/14/18 Effective and Termination Dates: 8/1/18 – 7/31/19					
PLAN COVERAGE <input type="checkbox"/> Student <input type="checkbox"/> Spouse (or Domestic Partner*) <input type="checkbox"/> One Child <input type="checkbox"/> Two or more Children <input type="checkbox"/> 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
				<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Domestic Partner*	<input type="checkbox"/> Student at _____ _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Enroll <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Vision Insurance _____ Carrier Name
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Enroll <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Vision Insurance _____ Carrier Name
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Enroll <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Vision Insurance _____ Carrier Name
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Enroll <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Vision Insurance _____ Carrier Name
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ _____ <input type="checkbox"/> Disabled <input type="checkbox"/> Enroll <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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
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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.