UnitedHealthcare Insurance Company
Enrollment Form - Vision

UnitedHealthcare Specialty Benefits

2014-200403-1

THE JOHN MARSHALL LAW SCHOOL

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	o Enroll o Cancel o Change o Address Change o Name Change Date of Change ___/___/___

LAST NAME	FIRST NAME	MI	ENROLLEE'S DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER Home ( ) Work ( )	o Male o Female o Single o Married
PLAN PERIOD o Annual Enrollment Deadline: 9/17/2014 Effective and Termination Dates: 8/4/2014-8/3/2015	

PLAN COVERAGE o Student o Student + Spouse (or Domestic Partner*) o Student + Child(ren) o 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	
		o Wife o Husband o Domestic Partner*	Student at _____	o Enroll o Change o Cancel o Male o Female
		o Son o Daughter	Student at _____	o Enroll o Change o Cancel o Male o Female
		o Son o Daughter	Student at _____	o Enroll o Change o Cancel o Male o Female
		o Son o Daughter	Student at _____	o Enroll o Change o Cancel o Male o Female
		o Son o Daughter	Student at _____	o Enroll o Change o Cancel o Male o 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/jmls, and select the Enroll Now link to enroll online.

* 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 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 -	$155.04	Student + Spouse	$310.28	Student + Domestic Partner	N/A	Student + Family	$416.84

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.