UnitedHealthcare Insurance Company
Enrollment Form - Vision

UnitedHealthcare

2020-1780-1

University of Maryland – Baltimore

IMPORTANT: Coverage will not begin until payment is received and processed.

Send completed application with check made payable to UnitedHealthcare StudentResources to:
First Risk Advisors, 67 West Court Street, Doylestown, PA 18091

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: 09/15/2020 Effective and Termination Dates: 08/1/2020-07/31/2021			
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	$137.04	Student + Spouse	$259.80	Student+ Child(ren)	$304.80	Student + Family	$428.64

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.firststudent.com, and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then 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.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties including imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

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 1-800-638-3120, TTY 711, 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.

嵚疢km꺙擋ペ崺ሰ襄 **(Chinese)**ꢂ僾⌧⁀彊鋘ペ堋∪嵱岏◣┴慺┴ꝏ嵚吔梻꺙1-800-638-3120ꝏ

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.

檝ꀀ: 覟ạ娏**(Korean)**≥ 乙峼覼翜亠 ロ崇 婕娏 晔嗇 PTE缶p.m.≥ ɦ⊙] 矸峼覼枩 ㇽ 弻1800-638-3120 ⫟ □] 悿賯覼摬翜訔.

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.

ó෩ 庑矺ㄒ **(Japanese)** ㅑ ᗰ ↓ ᐟ ㄒ ۊ ۺ ﮮ
1-800-638-3120 岍ㅑ

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 यान द: य द आप **हद (Hindi)** भाषी ह तो आपके लए भाषा सहायता सेवाएं न:शु क उपल ध ह । कृपा पर काल कर 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.

ចំ ប់ រម ណ ះ: េប សិនអ កនិ យ ែខរ **(Khmer)**េស ជំនួយ េ យឥតគិតៃថ គឺ នសំ ប់អក។ សូមទូរស័ព េ េលខ 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.