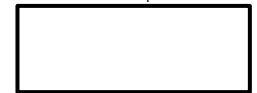


UNITEDHEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR DEPENDENTS ONLY



SOUTHERN COLLEGE OF OPTOMETRY

2022-938-61

<b>PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.</b>		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)	SCHOOL ID #:
PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)		
CITY:	STATE:	ZIP CODE:
TELEPHONE #:	EMAIL ADDRESS:	

<b>DEPENDENT INFORMATION</b>		
Complete information below for dependents to be insured. Dependent coverage is only available for students insured under the Plan (Please include a blank sheet for additional dependents).		
SPOUSE:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:

**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) The student has carefully read the Certificate of Coverage and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) The student meets the eligibility requirements for this coverage as described in the Certificate of Coverage; 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.

**NOTICE:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Student's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Campus Location:** Southern College of Optometry

I elect to purchase Injury and Sickness insurance coverage under the College's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY:  Graduate  Resident

ID Codes	Annual (A-)
2 Spouse	<input type="checkbox"/> \$ 2,754.00
3 One Child	<input type="checkbox"/> \$ 2,754.00
4 Two or more Children	<input type="checkbox"/> \$ 5,508.00
5 Spouse + two or more Children	<input type="checkbox"/> \$ 8,262.00

**NOTE:** The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

**EFFECTIVE/EXPIRATION PERIODS:** Annual 8/1/2022 to 7/31/2023

**Payment Instructions:** The charge is put onto your school student account. Please do not submit payment with this form.

Mail this enrollment form to:

First Risk Advisors  
67 W Court Street  
Doylestown, PA 18901

Or you may scan and Email this form to [customerservice@firstriskadvisors.com](mailto:customerservice@firstriskadvisors.com) or Fax to 267-880-2301



## NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does 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:

Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

You must send the written 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 member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

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 also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

## LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

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：1-866-260-2723。

XIN LUU 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 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 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。1-866-260-2723 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. 1-866-260-2723 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 1-866-260-2723

CEEBOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនជាអ្នកនិយាយ **ខ្មែរ (Khmer)** សូមទាក់ទងមកជាមួយសេវាជំនួយភាសាសម្រាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíí'k'eh, bee ná'ahóót'i'. T'áá shoodi kohj' 1-866-260-2723 hodílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.