



# University of Georgia

## Qualifying Life Event Request

### Nature of Your Qualifying Life Event:

If you experience a Qualifying Life Event (QLE) (e.g. loss of health insurance coverage, aged out of your parent's health insurance, marriage, etc.) during the plan year August 1, 2023 - July 31, 2024 you can enroll in the University of Georgia health insurance for the remainder of the current coverage period. Please complete this form and sign and date it.

### Reason for Qualifying Event:

☐ Loss of coverage under another plan

☐ Marital status

☐ Adoption of a child/birth of a child

☐ Guardianship appointment

☐ International Students: arrival of spouse/dependents in country

Date of Qualifying Life Event: \_\_\_\_\_

☐ Other (please detail) \_\_\_\_\_

---

---

---

---

### Primary Insured Information:

Gender: M ☐

F ☐

Name: \_\_\_\_\_  
(Last name, first name)

Student ID #: \_\_\_\_\_  
(Required)

Birth Date: \_\_\_\_\_  
(mm/dd/yyyy)

Address: \_\_\_\_\_  
(Street, City, State, ZIP)

Student Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
(Home phone or cell phone)

United  
Healthcare®

## Enrollment & Payment Instructions

A QLE is required for primary insureds and dependents to be eligible to enroll in the school health insurance plan at a time outside of the enrollment period. Enrollment in the plan must occur within 30 days of the QLE. Premiums are not pro-rated.

This form and your school injury and sickness insurance enrollment form, along with the required supporting documentation, must be submitted to UGA Human Resources at 215 S. Jackson Street; Athens, GA 30602 or via fax to 706-542-7321 for review and approval prior to being sent to UnitedHealthcare Student Resources.

**PAYMENT:** Once your QLE request is approved by UGA Human Resources, make check or money order payment to UnitedHealthcare Student Resources in US dollars. Mail this completed form, your school injury and sickness insurance enrollment form, required supporting documentation, along with premium payment to: UnitedHealthcare Student Resources; PO Box 809026; Dallas, TX 75380-9026.

**To pay with a credit card:** Once your QLE request is approved by UGA Human Resources, if you want to pay for your coverage with credit card or eCheck, email this completed form, your school injury and sickness insurance enrollment form, and required supporting documentation to [SIDHelp@uhcsr.com](mailto:SIDHelp@uhcsr.com) or fax it to 469-229-5612. Make sure your email address is correct as we will enter your coverage request into our system and send you an email message with instructions for making your premium payment online with a credit card or eCheck. Your cancelled check or credit card billing is your only receipt and notification of coverage.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For more information:** Contact UGA Human Resources at [gshiplan@uga.edu](mailto:gshiplan@uga.edu) or call 706-542-2222

### For Administrative Use Only:

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

Effective Enrollment Period Dates: \_\_\_\_\_

Approved By: \_\_\_\_\_

Premium Amount: \_\_\_\_\_

United  
Healthcare®

**UNITEDHEALTHCARE INSURANCE COMPANY**  
**QUALIFYING LIFE EVENT ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS**

UNIVERSITY OF GEORGIA

2023-202809-11

<b>PRIMARY INSURED</b> COMPLETE INFORMATION BELOW FOR STUDENT.			
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		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	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	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 card; 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:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

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

Campus/School Attending: \_\_\_\_\_

Please print name of University. Must be completed in order for application to be processed.

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

PLEASE CHECK ALL APPROPRIATE BOXES.

**INSURED CATEGORY:** ☐ Voluntary

ID Codes	Monthly (MX)
6 Student	<input type="checkbox"/> \$ 333.00
7 Spouse	<input type="checkbox"/> \$ 367.00
8 One Child	<input type="checkbox"/> \$ 367.00
9 Two or more Children	<input type="checkbox"/> \$ 734.00
10 Spouse and 2 or more Children	<input type="checkbox"/> \$ 1,101.00

**TO CALCULATE YOUR RATE:**

Rate x# of months eligible = amount due

Example: \$333.00 x 3 months = \$999.00

	Please multiply the rate and number of days and/or months to get your total premium.
Student	\$333.00 x ____ months = \$ ____
Spouse	\$367.00 x ____ months = \$ ____
One Child	\$367.00 x ____ months = \$ ____
Two or More Children	\$734.00 x ____ months = \$ ____
Spouse and 2 or More Children	\$1,101.00 x ____ months = \$ ____
Total	\$ ____

\*\* Please note: premiums are cumulative (Ex. Student + Spouse = Total premium due).

Requested Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Termination Date:

## NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources 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.



**Marathi**

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे.  
त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

**Marshallese**

Kwomaroŋi bōk jerbal in jipañ in kajin ilo ejjelōk wōpāñ. Jouj  
im kallōk 1-866-260-2723.

**Micronesian- Pohnpeian**

Mic sawas en mahsen ong komwi, soh isepe. Melau eker  
1-866-260-2723.

**Navajo**

Saad bee áka'e'eyeed bee áka'nida'wo'igfi t'áá jiik'eh bee nich'i  
bee ná'ahoot'i. T'áá shqōdi kohji! 1-866-260-2723 hodiilnih.

**Nepali**

भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया  
1-866-260-2723 मा कल गर्नुहोस्।

**Nilotic-Dinka**

Kāk ē kuny ajueer ē thok. atō tīnē yīn abac tē cīn wēu yeke  
thiēēc. Yīn cōl 1-866-260-2723.

**Norwegian**

Du kan få gratis språkhjelp. Ring 1-866-260-2723.

**Pennsylvania Dutch**

Schprooch iwwe-setze Hilf kannscht du frei hawwe. Ruf  
1-866-260-2723.

**Persian-Farsi**

خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره  
1-866-260-2723 تماس بگیرید.

**Polish**

Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń  
pod numer 1-866-260-2723.

**Portuguese**

Oferecemos serviço gratuito de assistência de idioma. Ligue  
para 1-866-260-2723.

**Punjabi**

ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਜ਼ਰੂਰੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ  
1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

**Romanian**

Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă  
rugăm să sunați la 1-866-260-2723.

**Russian**

Языковые услуги предоставляются вам бесплатно. Звоните  
по телефону 1-866-260-2723.

**Samoan- Fa'asamoa**

O lo maua fesoasoani mo gagana mo oe ma e lē totogia.  
Faamolemole telefoni le 1-866-260-2723.

**Serbo- Croatian**

Možete besplatno koristiti usluge prevodioca. Molimo nazovite  
1-866-260-2723.

**Somali**

Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa.  
Fadlan wac 1-866-260-2723.

**Spanish**

Hay servicios de asistencia de idiomas, sin cargo, a su  
disposición. Llame al 1-866-260-2723.

**Sudanic- Fulfulde**

Bi woodi walliinde dow wolde caahu ngam maada. Noodu  
1-866-260-2723.

**Swahili**

Huduma za msaada wa lugha zinapatikana kwa ajili yako bure.  
Tafadhali piga simu 1-866-260-2723.

**Syriac- Assyrian**

ܠܚܕܡܬܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ  
1-866-260-2723 ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ ܕܠܥܝܕܐ

**Tagalog**

Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng  
walang bayad. Mangyaring tumawag sa 1-866-260-2723.

**Telugu**

భాషా సహాయ సేవలు ని:శుల్క ఉపలబ్ధం. అందుబాటులో ఉన్నాయి.  
దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

**Thai**

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่าย  
แต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข  
1-866-260-2723

**Tongan- Fakatonga**

'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku  
'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he  
1-866-260-2723.

**Trukese (Chuukese)**

En mei tongeni angei aninisin emon chon chiakku, ese kamo.  
Kose mochen kopwe kokkori 1-866-260-2723.

**Turkish**

Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen  
1-866-260-2723 numaray ı arayınız.

**Ukrainian**

Послуги перекладу надаються вам безкоштовно. Дзвоніть за  
номером 1-866-260-2723.

**Urdu**

زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلا معاوضہ دستیاب ہیں۔  
برہمہدائی 1-866-260-2723 پر کل کریں۔

**Vietnamese**

Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui  
lòng gọi 1-866-260-2723.

**Yiddish**

שפראך הילף סערוויסעס זענען אוועקגעבן פאר איין פריי פון אפצאל. בייטש  
1-866-260-2723.

**Yoruba**

Isẹ lóránlọwọ èdè tí ó jẹ́ ọfẹ́, wà fún ọ. Pe 1-866-260-2723.