



University of Georgia

Qualifying Life Event Request

If you experience a Qualifying Life Event (QLE) during the plan year (08/1/2025 – 7/31/2026), you can enroll in the University of Georgia student health insurance plan (SHIP) for the remainder of the current coverage period. To request a QLE enrollment, please complete this form, sign and date it.

Reason for QLE:

☐ Loss of coverage under another plan

☐ Change in marital status

☐ Adoption of a child/birth of a child

☐ Guardianship appointment

☐ International Students: arrival of spouse/dependents in country

☐ Other (please explain) _____

Date of QLE: _____

Primary Insured Information:

Gender: ☐ M ☐ F

Name: _____
(Last name, First name)

Student ID #: _____
(Required)

Birth Date: _____
(mm/dd/yyyy)

Address: _____
(Street, City, State, ZIP)

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

Enrollment and 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 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.

To qualify for a QLE enrollment, one of the following documents must be submitted:

- Certificate of prior health coverage
- Marriage certificate
- Birth certificate or adoption papers
- Guardianship appointment papers
- International students: flight itinerary showing date of arrival in country

Student Signature: _____

Date: _____

For more information

Contact UGA Human Resources at gshiplan@uga.edu or Call 706-542-2222

**United
Healthcare**

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

UNIVERSITY OF GEORGIA

2025-202809-11

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.			
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	
MIDDLE INITIAL:			
GENDER: ☐ MALE ☐ 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:	

DEPENDENT INFORMATION 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: ☐ MALE ☐ FEMALE	
		DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: ☐ MALE ☐ FEMALE	
		DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: ☐ MALE ☐ FEMALE	
		DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: ☐ MALE ☐ FEMALE	
		DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD:		GENDER: ☐ MALE ☐ 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 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: 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	☐ \$ 344.00
7 Spouse	☐ \$ 378.00
8 One Child	☐ \$ 378.00
9 Two or more Children	☐ \$ 756.00
10 Spouse and 2 or more Children	☐ \$ 1,134.00

TO CALCULATE YOUR RATE:

Rate x# of months eligible = amount due
Example: \$344.00 x 3 months = \$1,032.00

	Please multiply the rate and number of days and/or months to get your total premium.
Student	\$344.00 x _____ months = \$ _____
Spouse	\$378.00 x _____ months = \$ _____
One Child	\$378.00 x _____ months = \$ _____
Two or More Children	\$756.00 x _____ months = \$ _____
Spouse and 2 or More Children	\$1,134.00 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

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: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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 باشند. 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 totoogia.
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

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 ఉపలబ్ధ అవుతున్నాయి.
దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai

มีการให้ความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่าย
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 numarayı 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 אוועלעביל פאר איין פריי פון אפצאל. בט"ש
1-866-260-2723 רופט

Yoruba

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