



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, no longer eligible on your parent's health insurance, marriage, etc.) during the plan year August 1, 2022 - July 31, 2023 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

Other (please detail) _____

Date of Qualifying Life Event: _____

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 **StudentResources**.

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

Student Signature: _____ Date: _____

FOR MORE INFORMATION: Contact UGA Human Resources at gshiplan@uga.edu or call 706-542-2222

FOR ADMINISTRATIVE USE ONLY:

Date:	_____
Effective Enrollment Period Dates:	_____
Approved By:	_____
Premium Amount:	_____



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

UNIVERSITY OF GEORGIA

2022-202809-41

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

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: <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: International Voluntary

- | | |
|----------------------------------|--------------------------------------|
| ID Codes | Monthly (MX) |
| 6 Student | <input type="checkbox"/> \$ 312.00 |
| 7 Spouse | <input type="checkbox"/> \$ 344.00 |
| 8 One Child | <input type="checkbox"/> \$ 344.00 |
| 9 Two or more Children | <input type="checkbox"/> \$ 687.00 |
| 10 Spouse and 2 or more Children | <input type="checkbox"/> \$ 1,030.00 |

TO CALCULATE YOUR RATE:

Rate x# of months eligible = amount due

Example: \$312.00 x 3 months = \$936.00

Please multiply the rate and number of days and/or months to get your total premium.	
Student	\$312.00 x ____ months = \$ _____
Spouse	\$344.00 x ____ months = \$ _____
One Child	\$344.00 x ____ months = \$ _____
Two or More Children	\$687.00 x ____ months = \$ _____
Spouse and 2 or More Children	\$1,030.00 x ____ months = \$ _____
Total	\$ _____

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

Requested Effective Date: ____ / ____ / ____

Termination Date:

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. Mail this enrollment form along with premium payment to:

UnitedHealthcare **StudentResources**
 PO Box 809026
 Dallas, TX 75380-9026.

Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

To pay with a credit card or eCheck:

Please complete the information in this enrollment form and email it to SIDHelp@uhcsr.com. Your coverage request will be registered and you will be sent a notification email with instructions for making your premium payment online. You may also fax this form to 469-229-5612.

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 <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.

