Loyola University Chicago
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 (8/1/2016-7/31/2017), you can enroll in the Loyola University Chicago health insurance for the remainder of the current coverage period. Please complete this form and sign and date it.

Reason for Qualifying Event (required supporting documentation in parentheses):

☐ Loss of coverage under parent's plan due to age restrictions (Letter of Ineligibility showing termination date)

☐ Marital Status (Marriage Certificate)

☐ Adoption of a Child/Birth of a Child (Adoption Paperwork/Birth Certificate)

☐ Guardianship Appointment (Guardianship Paperwork)

☐ International Students: Arrival of Spouse/Dependents in Country (Itinerary from the dependent's travel arrangements)

☐ Other (please detail) _____

Date of Qualifying Life Event: _____

STUDENT INFORMATION:

☐ Male
☐ Female

Name: _____
(Last name, first name)

SSN#: _____ **Student ID#:** _____ **Birth Date:** _____
(Required) (mm/dd/yyyy)

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

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

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 31 days of the QLE. Premiums are not pro-rated.

1. Make check or money order payable to UnitedHealthcare **Student**Resources. Mail this completed form, required supporting documentation, along with premium payment to: UnitedHealthcare **Student**Resources; PO Box 809026; Dallas, TX 75380-9026.

—OR—

2. If you want to pay for your coverage with a credit card or eCheck, email this completed form and required supporting documentation to SIDPremium-CustomerService@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.

If you have any questions please call UHCSR customer service at 1-866-808-8389.

Student Signature: _____ **Date:** _____

Continue to next page for enrollment information.

UnitedHealthcare®

Processor Date Stamp Received Here

UnitedHealthcare Insurance Company

Enrollment Form For Students And Their Dependents

Loyola University Chicago

2016-1291-1

PRIMARY INSURED Complete information below for student.

Social Security #: ____________________ Student ID #: ____________________

Last (Family) Name: ____________ First (Given) Name: ____________ Middle Initial: ______

Gender: ☐ Male ☐ Female Date of Birth: ____________ (Month/Day/Year) Expected Date of Graduation: ____________ (Month/Year)

Permanent US 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/Domestic Partner
Social Security #: ____________ Gender: ☐ Male ☐ Female Date of Birth: ____________ (Month/Day/Year)

First (Given) Name: ____________ Middle Initial: ______ Last (Family) Name: ____________

Child
Social Security #: ____________ Gender: ☐ Male ☐ Female Date of Birth: ____________ (Month/Day/Year)

First (Given) Name: ____________ Middle Initial: ______ Last (Family) Name: ____________

Child
Social Security #: ____________ Gender: ☐ Male ☐ Female Date of Birth: ____________ (Month/Day/Year)

First (Given) Name: ____________ Middle Initial: ______ Last (Family) Name: ____________

Child
Social Security #: ____________ Gender: ☐ Male ☐ Female Date of Birth: ____________ (Month/Day/Year)

First (Given) Name: ____________ Middle Initial: ______ Last (Family) Name: ____________

Child
Social Security #: ____________ 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) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this 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.

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 Signature: ________________________ **Date:** ____________

UnitedHealthcare®

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

INSURED CATEGORY:
Please check all appropriate boxes.

☐ Domestic Graduate ☐ Medical Student
☐ Domestic Undergraduate

ID Code		Spring (G-)	Summer (S-)	Monthly (MX-)
1	Student	☐ $1,738	☐ $729	☐ $242
2	Spouse/Domestic Partner	☐ $1,738	☐ $729	☐ $242
3	One Child	☐ $1,738	☐ $729	☐ $242
4	Two or More Children	☐ $3,476	☐ $1,458	☐ $485
5	Spouse + Two or More Children	☐ $5,214	☐ $2,187	☐ $727

NOTE: The amounts stated above may 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:

☐ Spring 1/1/2017 to 7/31/2017

☐ Summer 5/1/2017 to 7/31/2017

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due [Example: $242 x 3 months = $726]

Rate x # of months eligible + Period = amount due [Example: 12/1/16-7/31/17 1 month ($242) + Spring ($1,738) = 1,980]

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $_____

Multiply by # of months: _____

Spring or Summer Premium (if applicable): $_____

Total premium enclosed: $_____

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