UNITEDHEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR DEPENDENTS OF INTERNATIONAL STUDENTS

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UNIVERSITY OF COLORADO DENVER INTERNATIONAL

2019-202710-4

Date: _____

PRIMARY INSURED COMPLETE IN	FORMATION BELOW FOR STUD	ENI.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NA	ME:		MIDDLE INITIAL:
GENDER:	DATE OF BIRTH: (MONTH/DAY/YEAR)		SCHOO	DL ID #:
PERMANENT U.S. ADDRESS: (HOUS	L E/BUILDING # AND STREET NAM	E)	I	
CITY:		STATE:	Z	IP CODE:
TELEPHONE #:		EMAIL ADDRI	ESS:	
DEPENDENT INFORMATION Complete information below for Dep	pendents to be insured. Depende	ent coverage is	only available for	Students insured under the Plar
(Please include a blank sheet for ad			-	
SPOUSE:	GENDER:	☐ FEMALE	DATE OF BIRTI (MONTH/DAY/	
First (Given) Name:	Middle Initial:	L	ast (Family) Name	e:
CHILD:	GENDER:	☐ FEMALE	DATE OF BIRTI	
First (Given) Name:	Middle Initial:	L	ast (Family) Name	e:
CHILD:	GENDER:		DATE OF BIRTI	
First (Given) Name:	Middle Initial:	L	ast (Family) Name	e:
CHILD:	GENDER:		DATE OF BIRTI	
First (Given) Name:	Middle Initial:	L	ast (Family) Name	e:
CHILD:	GENDER:		DATE OF BIRTI	
First (Given) Name:	Middle Initial:	L	ast (Family) Name	ə:
OTICE TO STUDENT: Coverage will be Company or the effective date of the estudent acknowledges the following this enrollment form; 2) Rates are requirements for this coverage as desigible, the premium will be refunded. OTICE: It is unlawful to knowingly purpose of defrauding or attempting to amages. Any insurance company or a information to a policyholder or claim	the coverage period, whichever is g: 1) The student has carefully remot pro-rated other than as listed scribed in the Certificate of Coveremium will not be refunded expressed to the company. Penalties agent of an insurance company	later, unless of ad the Certificated on this enrol errage; and 4) accept for ineligible deading facts of a may include if who knowingly	therwise stated in ate of Coverage and Ilment form; 3) The If it is later determined bility or entrance or information to a provide false, in provides false, in	the Master Policy. By signing, nd elects to enroll as indicated the student meets the eligibility mined that the student is not into the armed forces. an insurance company for the es, denial of insurance and civil

Department of Regulatory Agencies.

Student's Signature:

☐ I elect to purchase Injury and are the choices I have made.	Sickness insurance	e coverage under the	University's stu	ident insurance plan. Below
PLEASE CHECK ALL APPROPRIATE BO	OXES.			
	☐ International			
ID Codes	Fall (F-)	Spring/Summer (J-)	Summer (S-)	Monthly (MX-)
2 Spouse	□ \$ 543.00	□ \$ 757.00	□ \$ 217.00	□ \$ 109.00
3 One Child	□ \$ 543.00	□ \$ 757.00	□ \$ 217.00	□ \$ 109.00
4 Two or more Children	□ \$ 1,086.00	□ \$ 1,514.00	□ \$ 434.00	□ \$ 218.00
5 Spouse and 2 or more Children	□ \$ 1,629.00	□ \$ 2,271.00	□ \$ 651.00	□ \$ 327.00
NOTE: The amounts stated above in may, for example, cover your school's			-	
EFFECTIVE/EXPIRATION PERIODS:		ENROLLMENT DEADL	INE:	
☐ Fall 8/01/2019 to	12/31/2019	10/06/2019		
☐ Spring/Summer 1/01/2020 to	7/31/2020	03/01/2020		
☐ Summer 6/01/2020 to	7/31/2020	07/31/2020		
EFFECTIVE AND TERMINATION DATE Coverage will become effective on to be ayment. Please Note: If application and correct application and correct premium are recomplication.	he date the authori premium are received reived. Requested Eff	d after this requested efective Date:/	ffective date, you	
Rate x # of months eligible = amount		culate Your Rate: \$109.00 x 3 months = \$	\$327.00	
	·		·	
CALCULATION FOR MONTHLY PR	EMIUM:			
Monthly premium: \$	_			
Multiply by # of months:				
Total premium enclosed: \$				
Payment Instructions: Make check enrollment card along with premium punitedHealthcare StudentResources PO Box 809026 Dallas, TX 75380-9026.	payment to:	able to UnitedHealthca	re Student Reso	urces in US dollars. Mail this
Your cancelled check is your only red whether or not a premium notice is re		of coverage. The stude	ent is responsible	for timely premium payments
OW TO ENROLL OR PAY ONLINE:				

Н

Dependents Only:

If the primary insured purchases coverage through their school, they can request to be notified when dependent coverage is available to purchase once the primary insured's coverage is in force. To complete this request, visit uhcsr.com/control and select "Notify me" and complete the form. Once the primary insured's coverage is in force, a notification email will be sent indicating that dependent coverage can be purchased.

The State of Colorado requires UnitedHealthcare Insurance Company to request the following information about the Primary Insured. You may select a primary and secondary race, a primary and secondary ethnicity, and a primary language. If you choose not to supply this information please select the box below.

 $\hfill\square$ I have read the request for information and choose not to supply a response.

Prir	Primary Race (select one)				
	R1	American Indian / Alaska Native			
	R2	Asian			
	R3	Black / African American			
	R4	Native Hawaiian or other Pacific Islander			
	R5	White			
	R9	Other (please enter)			
	UNKNOWN	Unknown / Not Specified			

Sec	Secondary Race (select one)			
	R1	American Indian / Alaska Native		
	R2	Asian		
	R3	Black / African American		
	R4	Native Hawaiian or other Pacific Islander		
	R5	White		
	R9	Other (please enter)		
	UNKNOWN	Unknown / Not Specified		

Are you Hispanic/Latino/Spanish: ☐ Yes ☐ No ☐ Unknown

Drin	Primary Ethnicity (select one)				
	2060-2	African			
	2058-6	African American			
	AMERCN	American			
H	2028-9	Asian			
	2020-9	Asian Indian			
		Brazilian			
Щ	BRAZIL				
Щ	2033-9	Cambodian			
	CVERDN	Cape Verdean			
	CARIBI	Caribbean Island			
	2155-0	Central American (not otherwise specified)			
	2034-7	Chinese			
	2169-1	Columbian			
	2182-4	Cuban			
	2184-0	Dominican			
	EASTEU	Eastern European			
	2108-9	European			
	2036-2	Filipino			
	2157-6	Guatemalan			
	2071-9	Haitian			
	2158-4	Honduran			
	2039-6	Japanese			
	2040-4	Korean			
	2041-2	Laotian			
	2148-5	Mexican, Mexican American, Chicano			
	2118-8	Middle Eastern			
	PORTUG	Portuguese			
	2180-8	Puerto Rican			
	RUSSIA	Russian			
	2161-8	Salvadoran			

Secondary Ethnicity (select one)					
	2060-2	African			
	2058-6	African American			
	AMERCN	American			
	2028-9	Asian			
	2029-7	Asian Indian			
	BRAZIL	Brazilian			
	2033-9	Cambodian			
	CVERDN	Cape Verdean			
	CARIBI	Caribbean Island			
	2155-0	Central American (not otherwise specified)			
	2034-7	Chinese			
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	EASTEU	Eastern European			
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	2157-6	Guatemalan			
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	2039-6	Japanese			
	2040-4	Korean			
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	2148-5	Mexican, Mexican American, Chicano			
	2118-8	Middle Eastern			
	PORTUG	Portuguese			
	2180-8	Puerto Rican			
	RUSSIA	Russian			
	2161-8	Salvadoran			

Prir	Primary Ethnicity (select one)			
	2165-9	South American (not otherwise specified)		
	2047-9	Vietnamese		
	OTHER	Other (please specify)		
	UNKNOWN	Unknown / Not Specified		

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Secondary Ethnicity (select one)			
	2165-9	South American (not otherwise specified)	
	2047-9	Vietnamese	
	OTHER	Other (please specify)	
	UNKNOWN	Unknown / Not Specified	

Primary Language (select one)						
	799	African Languages (please specify)		724	Korean	
	777	Arabic		656	Persian	
	708	Chinese (please specify)		645	Polish	
	601	Cape Verdean Creole		629	Portuguese	
	600	English		639	Russian	
	620	French		625	Spanish	
	607	German		742	Tagalog	
	637	Greek		671	Urdu	
	623	Haitian Creole		728	Vietnamese	
	778	Hebrew		997	Other (please specify)	
	663	Hindi		998	Declined	
	619	Italian		999	Unavailable	
	723	Japanese				

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.

LANGUAGE ASSISTANCE PROGRAM

We 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 toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amhari

የቋንቋ አርዳታ አንልማሎቶች በነጻ ይንኛሉ። አባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 2723-260-866.

Armenian

Ձեզ մատչելի են անվՃար լեզվական օգնության ծառայություններ։ Խնդրում ենք զանգահարել 1-866-260-2723 համարով։

Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্য পেতে পারেন। দ্য়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ် ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee

\$የጋኬብ፡፡መJ ወቀር፡፡ውያጓJ ወቀር፡ውET ኬብ RG6º፡ውፐ፡፡መር፡፡ብጓT ከLEGG6º D4፡፡መT. IGO Dh ወচW6ን\$ 1-866-260-2723.

Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla hochi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole-Haitian Creole

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Crook

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Guiarati

ભાષા સહ્યય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર ક્રૉલ કરો.

Hawaiian

Kōkua manuahi ma kāu 'ōlelo i loa'a 'ia. E kelepona i ka helu 1-866-260-2723.

Hindi

आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

The

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese

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 までお電話ください。

Karen

ကျိ႒်တာမေစၤ၊အင်္ကိုနမၤန္ ါအီးသဲ့ဝဲလၢတလိ႒်ဟ္႒်အပူးဘဉ်(ဒီလီ)နှဉ်လီး. ငံသးစူးဆုံးကျိုးဘဉ် 1-866-260-2723တက္ကာ်.

Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمەتەكلنى يارمەتيى زمانى بەخۆر ايى بۆ تۆ دابين دەكريّن. تكايە تىلمەقۆن بىكە بۆ ژمارەي 2723-266-1.

Laotian

ີ່ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄໍ່າໃຫ້ແກ່ທໍ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi

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

Marshallese

Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjelok wōṇāān. Jouj im kallok 1-866-260-2723.

Micronesian-Pohnpeian

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

Navajo

Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'i' bee ná'ahoot'i'. T'áá shoodí kohji' 1-866-260-2723 hodíilnih.

Nepali

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

Nilotic-Dinka

Käk ë kuny ajuser ë thok atö tinë yin abac të cin wëu yeke thiëëc. Yin col 1-866-260-2723.

Norwegian

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

Pennsylvania Dutch

Schprooch iwwesetze 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 شمار ه 2723-866-260 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 ਤੁਹਾਡੇ 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 loo 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

E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

Swahil

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

Syriac- Assyrian

چەچەققە تەخبەقە ياغتە، خەختەبىد، سىلا ھەبە ئالەممى . مىنىنەممە مەنى خەرسىنە ھەبەر 1.86-260-260.

Tagalog

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

Telugi

లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่า ยแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข

1-866-260-2733

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.

Ukrainiar

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

Urdu

زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 2723-260-1866 پر کال 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 אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723

Yoruba

Isé ìrànlówó èdè tí ó jé òfé, wà fún ó. Pe 1-866-260-2723.