

# University of Colorado – Denver International 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 (8/1/19 – 07/31/20), you can enroll in the University of Colorado – Denver International 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:

Name: \_\_\_\_\_

(Last name, first name)

School ID #: \_\_\_\_\_

(Required)

## ENROLLMENT & PAYMENT INSTRUCTIONS:

A QLE is required for the primary insured 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.

To pay with a credit card or eCheck: Email this completed form and your school injury and sickness insurance enrollment form to [sidhelp@uhcsr.com](mailto: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.

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

**FOR MORE INFORMATION:** Call 1-800-767-0700 or Email [customerservice@uhcsr.com](mailto:customerservice@uhcsr.com).

## FOR ADMINISTRATIVE USE ONLY:

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

Effective Enrollment Date: \_\_\_\_\_

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

UNITEDHEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR QUALIFYING LIFE EVENT STUDENTS

UNIVERSITY OF COLORADO – DENVER INTERNATIONAL

2019-202710-4

<b>PRIMARY INSURED</b> 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:	

<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 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:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

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

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

Campus/School Attending: University of Colorado Denver International

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:**                     English Language Program                     International  
 Practical Training

ID Codes	Monthly (MX)
1 Student	<input type="checkbox"/> \$ 184.00
2 Spouse / Domestic Partner	<input type="checkbox"/> \$ 109.00
3 One Child	<input type="checkbox"/> \$ 109.00
4 Two or more Children	<input type="checkbox"/> \$ 218.00
5 Spouse and 2 or more Children	<input type="checkbox"/> \$ 327.00

**NOTE:** The amounts stated above 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 AND TERMINATION DATES:**

**Coverage will become effective on the date the Insurance Company authorized representative receives the application and correct premium payment.**

Monthly coverage expires 1 month following receipt of your premium or 7/31/2020, whichever is earlier.

**Please Note:** If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. Requested Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

<b>TO CALCULATE YOUR RATE:</b>	
Rate x # of months eligible = amount due	Example: \$184.00 x 3 months = \$552.00
<b>CALCULATION FOR MONTHLY PREMIUM:</b>	
Monthly premium: \$ _____	
Multiply by # of months: _____	
Total premium enclosed: \$ _____	
<b>Payment Instructions:</b> Make check or money order payable to UnitedHealthcare <b>StudentResources</b> in US dollars. Mail this enrollment card along with premium payment to:	
UnitedHealthcare <b>StudentResources</b> 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](mailto: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.

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.

I have read the request for information and choose not to supply a response.

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

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

Are you Hispanic/Latino/Spanish:     Yes                       No                       Unknown

Primary Ethnicity (select one)		
<input type="checkbox"/>	2060-2	African
<input type="checkbox"/>	2058-6	African American
<input type="checkbox"/>	AMERCN	American
<input type="checkbox"/>	2028-9	Asian
<input type="checkbox"/>	2029-7	Asian Indian
<input type="checkbox"/>	BRAZIL	Brazilian
<input type="checkbox"/>	2033-9	Cambodian
<input type="checkbox"/>	CVERDN	Cape Verdean
<input type="checkbox"/>	CARIBI	Caribbean Island
<input type="checkbox"/>	2155-0	Central American (not otherwise specified)
<input type="checkbox"/>	2034-7	Chinese
<input type="checkbox"/>	2169-1	Columbian
<input type="checkbox"/>	2182-4	Cuban
<input type="checkbox"/>	2184-0	Dominican
<input type="checkbox"/>	EASTEU	Eastern European
<input type="checkbox"/>	2108-9	European
<input type="checkbox"/>	2036-2	Filipino
<input type="checkbox"/>	2157-6	Guatemalan
<input type="checkbox"/>	2071-9	Haitian
<input type="checkbox"/>	2158-4	Honduran
<input type="checkbox"/>	2039-6	Japanese
<input type="checkbox"/>	2040-4	Korean
<input type="checkbox"/>	2041-2	Laotian
<input type="checkbox"/>	2148-5	Mexican, Mexican American, Chicano
<input type="checkbox"/>	2118-8	Middle Eastern
<input type="checkbox"/>	PORTUG	Portuguese
<input type="checkbox"/>	2180-8	Puerto Rican
<input type="checkbox"/>	RUSSIA	Russian
<input type="checkbox"/>	2161-8	Salvadoran

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<input type="checkbox"/>	PORTUG	Portuguese
<input type="checkbox"/>	2180-8	Puerto Rican
<input type="checkbox"/>	RUSSIA	Russian
<input type="checkbox"/>	2161-8	Salvadoran

Primary Ethnicity (select one)		
<input type="checkbox"/>	2165-9	South American (not otherwise specified)
<input type="checkbox"/>	2047-9	Vietnamese
<input type="checkbox"/>	OTHER	Other (please specify)
<input type="checkbox"/>	UNKNOWN	Unknown / Not Specified

Secondary Ethnicity (select one)		
<input type="checkbox"/>	2165-9	South American (not otherwise specified)
<input type="checkbox"/>	2047-9	Vietnamese
<input type="checkbox"/>	OTHER	Other (please specify)
<input type="checkbox"/>	UNKNOWN	Unknown / Not Specified

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

Kwomaron bok jermal in jipañ in kajin ilo ejjelok wōṇāñ. 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 aka'e'eyeed bee aka'nida'wo'igii t'aa jiiik'eh bee nich'i' bee na'ahoot'i'. T'aa shqodi kohji' 1-866-260-2723 hodilnih.

**Nepali**

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

**Nilotic-Dinka**

Kak e kuny ajueer e 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**

Schprouch 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 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 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- F Fulfulde**

E 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**

1-866-260-2723

**Tagalog**

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

**Telugu**

1-866-260-2723

**Thai**

1-866-260-2733

**Tongan- Fakatonga**

1-866-260-2723

**Trukese (Chuukese)**

1-866-260-2723

**Turkish**

1-866-260-2723

**Ukrainian**

1-866-260-2723

**Urdu**

1-866-260-2723

**Vietnamese**

1-866-260-2723

**Yiddish**

1-866-260-2723

**Yoruba**

1-866-260-2723