**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. 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.

**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

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.

<table>
<thead>
<tr>
<th>LAST (FAMILY) NAME:</th>
<th>FIRST (GIVEN) NAME:</th>
<th>MIDDLE INITIAL:</th>
</tr>
</thead>
</table>

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: [ ] MALE [ ] FEMALE DATE OF BIRTH: (MONTH/DAY/YEAR)

First (Given) Name: ___________________________ Middle Initial: ___________________________ Last (Family) Name: ___________________________

CHILD: [ ] MALE [ ] FEMALE DATE OF BIRTH: (MONTH/DAY/YEAR)

First (Given) Name: ___________________________ Middle Initial: ___________________________ Last (Family) Name: ___________________________

CHILD: [ ] MALE [ ] FEMALE DATE OF BIRTH: (MONTH/DAY/YEAR)

First (Given) Name: ___________________________ Middle Initial: ___________________________ Last (Family) Name: ___________________________

CHILD: [ ] MALE [ ] FEMALE DATE OF BIRTH: (MONTH/DAY/YEAR)

First (Given) Name: ___________________________ Middle Initial: ___________________________ Last (Family) Name: ___________________________

CHILD: [ ] 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: 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          ☐ $ 184.00
2  Spouse / Domestic Partner  ☐ $ 109.00
3  One Child          ☐ $ 109.00
4  Two or more Children ☐ $ 218.00
5  Spouse and 2 or more Children ☐ $ 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: _____/_____/_____.

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due  Example: $184.00 x 3 months = $552.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $___________
Multiply by # of months: ____________
Total premium enclosed: $___________

Payment Instructions: Make check or money order payable to UnitedHealthcare StudentResources in US dollars. Mail this enrollment card 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.
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.

<table>
<thead>
<tr>
<th>Primary Race (select one)</th>
<th>Secondary Race (select one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ R1 American Indian / Alaska Native</td>
<td>☐ R1 American Indian / Alaska Native</td>
</tr>
<tr>
<td>☐ R2 Asian</td>
<td>☐ R2 Asian</td>
</tr>
<tr>
<td>☐ R3 Black / African American</td>
<td>☐ R3 Black / African American</td>
</tr>
<tr>
<td>☐ R4 Native Hawaiian or other Pacific Islander</td>
<td>☐ R4 Native Hawaiian or other Pacific Islander</td>
</tr>
<tr>
<td>☐ R5 White</td>
<td>☐ R5 White</td>
</tr>
<tr>
<td>☐ R9 Other (please enter)</td>
<td>☐ R9 Other (please enter)</td>
</tr>
<tr>
<td>☐ UNKNOWN Unknown / Not Specified</td>
<td>☐ UNKNOWN Unknown / Not Specified</td>
</tr>
</tbody>
</table>

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

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

- [ ] 2165-9 South American (not otherwise specified)
- [ ] 2047-9 Vietnamese
- [ ] OTHER Other (please specify)
- [ ] UNKNOWN Unknown / Not Specified

### 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)
- [ ] 777 Arabic
- [ ] 708 Chinese (please specify)
- [ ] 601 Cape Verdean Creole
- [ ] 600 English
- [ ] 620 French
- [ ] 607 German
- [ ] 637 Greek
- [ ] 623 Haitian Creole
- [ ] 778 Hebrew
- [ ] 663 Hindi
- [ ] 619 Italian
- [ ] 723 Japanese

- [ ] 724 Korean
- [ ] 656 Persian
- [ ] 645 Polish
- [ ] 629 Portuguese
- [ ] 639 Russian
- [ ] 625 Spanish
- [ ] 742 Tagalog
- [ ] 671 Urdu
- [ ] 728 Vietnamese
- [ ] 997 Other (please specify)
- [ ] 998 Declined
- [ ] 999 Unavailable

- [ ] 663 Hindi
- [ ] 619 Italian
- [ ] 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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)


Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)


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, 9 a.m. to 9 p.m. ET.

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

Albanian

Amharic
አማርኛ እንወርእ ይህ የሚገኝ ቀሪብ ያሆኔ ለማስተካከል ከስተወር በማሸጠ ተልስ ለማስተካከል ያለ የተደረገው የሚገኝ የሚገኝ 1-866-260-2723ውን ያስተወር.

Arabic
توفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ կկարողին թե նախագծային օգնության համար հեռահաղ լուծ ուղարկեք 1-866-260-2723-ի համար.

Bantu- Kirundi
Uronswa ku bantu serivisi zifataye ku ru'imi zo kugufasha. Utegerewe guhamugara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Bengali- Bangla
বাংলা : ভাষা সহায়তা পরিকাঠামো আপনি বিস্তারিত পেতে পারেন। সাহায্য করার 1-866-260-2723-এ কল করুন।

Burmese
သင်ကြားရန်အတွက် ထိန်းချုပ်ရန် အကြောင်း ဗိသုကာပြုလုပ်မှုအချက်များ ဖော်ပြသည်။ 1-866-260-2723-အတွက် အေနစားပါ။

Cambodian- Mon-Khmer
ការបង្ហាញពីប្រធានបទនៃការជួសជុ.publisher ជប៉ុនប្រអប់រំទំនើប 1-866-260-2723។

Cherokee
CHerokee, OPOA,0J OPOA-B0,0J OPOA-ET 1/0R GE079,T901,978 ET HEGGA0D D407,1, EG 01, 1D BH09D 1-866-260-2723.

Chinese
您可以免费获得语言援助服务。请致电 1-866-260-2723。

Chocaw
Chahat anampa ish anumpali hokmwt toshboli yv t peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaalillwam gargaarsa afararni kafaltii maaee siif jira. Maalo kooroo kaaloooba bilbilis 1-866-260-2723 bilbilis.

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

French

French Creole- Haitian Creole

German

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

Gujarati
ભાષા સહાય સેવાઓ અમારા માટે મિશ્રસ્થિતિ ઉપલબ્ધ છે. કૂટનીએ 1-866-260-2723 પર કોલ કરો.

Hawaiian
Kūkōa manuahi ma kū ‘olelo i loa’a ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निश्चित प्रविधि हैं। कूपाय 1-866-260-2723 पर कॉल करिए।

Hmong
Mhaj cov kev pab thais lus pub dawb rau koij. Thow lu rau 1-866-260-2723.

Ibo

Ilocano
Adda awan bayadana a serbisyo para iti language assistance. Pungasimis ta twagam ti 1-866-260-2723.

Indonesian

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
လူမျိုးဆောင်ရွက်ရေးမှုန်းရေးစစ်ဆေးရေးနိုင်ငံတော်လော် 1-866-260-2723တွင် ဖော်ပြပါ။

Korean
연어 지원 서비스는 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하시십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsu wogu wo ba ye ha i nyu yop. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خۆزەخانەکانی برترینی زمانی باشتوشی بز تەو دەکرێن. ناکیەکانەوە بە بز زمەنی 1-866-260-2723.

Laotian
ມີເບັບສາດຖານທາງແບບຄວາມເສຍເສຍຈາກເທດອາເມລິກາ. ນາງກູນໜ້າປະຊາທິບ 1-866-260-2723.
Marathi
माजीच्या मुलाची सुविधा आपणास निर्माण की बनवाणे आहे.
त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Micronesian- Pohnpeian
Mie savas en mahsen eng kornwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saap bee åka’er’eyee bēk åka’i’di’o’wō’ii’gii t’āj jii’jii’ee bee ní’ahsh’i’i. T’ā shōddii kohii’j 1-866-260-2723 hodilihii.

Nepali
भाषा सहायता सेवालाई निर्देश आफ्नो उपलब्ध छ। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilo-Saharan- Dinka

Norwegian

Pennsylvania Dutch

Persian-Farsi
خدمات امرای زبانی به طور رایگان به‌این‌جا می‌باشد. لطفاً با ما تماس بگیرید. 1-866-260-2723

Polish
Mógłeś skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferemos serviço gratuito de assistência de idiomas. Ligue para 1-866-260-2723.

Punjabi
ਅਸਾ ਸਭਿਟਵਾਂ ਇੰਦੀਆ ਦੇ ਦੋ ਜ਼ਿਲਾ ਪੁਲਿਸਕਰਸ਼ ਤਲਾ ਵਿਕਾਸ ਵਹਾਂ 1-866-260-2723 ਦੇ ਹੋਰ ਵਾਲੇ ਹਨ।

Romanian
Vi se pun la dispozitie, 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.

Somali
Adeegyada tangeerada luqadda oo bilaash ah ayaan la heli kama. Fadlan wac 1-866-260-2723.

Spanish
Hoy servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanese- Fulfulde

Swahili
Huduma za maada wa lugha zinapatikana kwa ajili yake bure. Tafadhali pigwa simu 1-866-260-2723.

Syriac- Assyrian
نمرسنجي، مساريا، سوري يفتخر باللغة العربية. 1-866-260-2723

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walong buhay. Mangyaring tumawag sa 1-866-260-2723.

Telugu
మానవులలో ఆధారంగా ప్రతి భాషా వినియోగించి మన సాంస్కృతిక శక్తిని సహాయం చేసే సంస్థ. 1-866-260-2723 లో క్లిఫ్‌ చేసేందుకు అవసరం.

Thai
มีบริการความช่วยเหลือทางภาษาไทยโดยไม่ต้องเสียค่าใช้จ่าย ตลอดทุกเวลา โดยตรงจากศูนย์บริการ 1-866-260-2723.

Tongan- Fakatonga
‘Oka’i ai pō ‘a e sēvesi ki he lea’ ke tokoni kiaete koa pea ‘okau ‘a tāia ma'a ‘o ‘i kai ha totongi. Kātaki ‘o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angeni amisin emon chon chia ak, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarasını arayınız.

Ukrainian
Послугу перевідної надається вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کر حوالی سے معاونتی خدمات آپ کو زبان لکھنے سے متاثر ہونے کی مدد کے لئے ہیں۔ 1-866-260-2723

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
spNetak licht un groysh. Mem moge vaks geyn fayn un deutsch. 1-866-260-2723

Yoruba