# 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 (8/1/20 – 07/31/21), 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:

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**PRIMARY INSURED INFORMATION:**

Name: __________________________ (Last name, first name)

School ID #: ________________________ (Required)

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**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: __________________________

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**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: _______________

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19COL3839-202710-4
UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR QUALIFYING LIFE EVENT STUDENTS
UNIVERSITY OF COLORADO – DENVER INTERNATIONAL 2020-202710-4

<table>
<thead>
<tr>
<th>PRIMARY INSURED</th>
<th>COMPLETE INFORMATION BELOW FOR STUDENT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST (FAMILY) NAME:</td>
<td>FIRST (GIVEN) NAME:</td>
</tr>
<tr>
<td>GENDER:</td>
<td>□ MALE</td>
</tr>
<tr>
<td>PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)</td>
<td></td>
</tr>
<tr>
<td>CITY:</td>
<td>STATE:</td>
</tr>
<tr>
<td>TELEPHONE #:</td>
<td>EMAIL ADDRESS:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEPENDENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>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).</td>
</tr>
</tbody>
</table>

**SPOUSE:**
- GENDER: □ MALE □ FEMALE
- DATE OF BIRTH: (MONTH/DAY/YEAR)
- First (Given) Name: Middle Initial: Last (Family) Name:

**CHILD:**
- 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) 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: ________________

EF-2019-CO 1 of 4
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 ☐ $186.00
2 Spouse / Domestic Partner ☐ $107.00
3 One Child ☐ $107.00
4 Two or more Children ☐ $214.00
5 Spouse and 2 or more Children ☐ $321.00

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 7/31/2021, 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: $186.00 x 3 months = $558.00

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>
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<tr>
<td>☐ 2169-1 Columbian</td>
<td>☐ 2169-1 Columbian</td>
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<tr>
<td>☐ 2182-4 Cuban</td>
<td>☐ 2182-4 Cuban</td>
</tr>
<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>
</tr>
<tr>
<td>☐ 2036-2 Filipino</td>
<td>☐ 2036-2 Filipino</td>
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<tr>
<td>☐ 2157-6 Guatemalan</td>
<td>☐ 2157-6 Guatemalan</td>
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<td>☐ 2071-9 Haitian</td>
<td>☐ 2071-9 Haitian</td>
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<tr>
<td>☐ 2158-4 Honduran</td>
<td>☐ 2158-4 Honduran</td>
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<tr>
<td>☐ 2039-6 Japanese</td>
<td>☐ 2039-6 Japanese</td>
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<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

Secondary Language (select one)
- 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
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


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 9 p.m. ET.

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

Albanian

Amharic
አማርኛCHA Matthews የሸውነት እና ያስገነዝባ ያከፈለኝ ያሉ ማስገኘ መን ቅኝ በ 1-866-260-2723 ይታገባል።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانيًا. اتصل على الرقم 1-866-260-2723.

Armenian
Հերբեռի է ներկայացնում երեխայի օգնությունը. Համարենք, առաջադրվում է կարողանակություն 1-866-260-2723 համառում}

Bantu - Kirundi
Uronswa ku bantu servisivu zifatiywe ku ruirim zo kugufasha. Utegerewa guhugurana 1-866-260-2723.

Bisayan - Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walyay bayad. Palihug tawag sa 1-866-260-2723.

Bengali - Bangla
বুলিগুলি তাছে সহজ পরিষেবা আসছি বিস্মৃতি পেতে পারেন। দুর্য করে আপনি ১-৮৬৬-২৬০-২৭২৩-এ কল করুন।

Burmese
ထို့ကို အောင်မြင်စေတီလေး အားလုံးအမြင် ရရှိနိုင်စော ဗိုလ်ချူး 1-866-260-2723 ကြည့်ပါ။

Cambodian - Mon-Khmer
តារារាជមាសវាច្រៀងសេវានិងជូនអតីតសេវារដ្ឋបាលេ 1-866-260-2723 ។

Cherokee
Speak to one of our qualified interpreters in English, French, Spanish, Chinese or American Sign Language.

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

Chotaw
Chhàta anampa ish anumpuli hocnwt toshholi yvt peh pilla ho chi apela hima. I paya 1-866-260-2723.

Cushite - Oromo
Tajajallawan gargaarsa afaanii kanfaltii malee siif jira. Maalo kaara lakoobsa bilblaa 1-866-260-2723 bilbli.

Dutch
Taalbijstandsdiener 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 sèv ouch pou ki disponb gratis pou ou. Rele 1-866-260-2723.

German

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλωσήρετε στο 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ માટે માટે વિશ્વક્રિયા છે. ડિશ કરીને 1-866-260-2723 પર કોલ કરો.

Hawaiian
Kūlea mamahī ma kāu ʻolelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाओं निश्चित उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Mhaj cov kev pawt taihais lua pub dawb rau koj. Thow lu rau 1-866-260-2723.

Ibo

Ilocano
Adda awan bayadana a serbisyo para iti language assistance. Punggasiim ta tawagim 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 でお電話ください。

Karen

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

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

Kurdish Sorani
خەمەتەکاری زەمارەی زمانی بەبەری ژێر دەبێت، نەکەی نەمەتەوە ژێر. 1-866-260-2723.

Laotian
นี้เป็นบริการช่วยที่ใช้เป็นภาษาเพื่อความสะดวก. บริการโทรศัพท์ 1-866-260-2723.