

UNITEDHEALTHCARE INSURANCE COMPANY  
CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF UTAH

2023-2310-1

<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 immediately following the expiration of the regular student plan and must be purchased within 30 days after the expiration date of your student coverage. If premium is not received within 30 days, the premium will be refunded. 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:** 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's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Campus Location: UNIVERSITY OF UTAH

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

Eligibility: All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 consecutive months and who no longer meet the eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than 6 months under the school's policy in effect. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

PLEASE CHECK ALL APPROPRIATE BOXES.

**INSURED CATEGORY:**       Continuation

Period Codes	Monthly (MX)
	(6 months maximum)

ID Codes	
6 Student	<input type="checkbox"/> \$ 226.00
7 Spouse	<input type="checkbox"/> \$ 225.00
8 One Child	<input type="checkbox"/> \$ 225.00
9 Two or more Children	<input type="checkbox"/> \$ 450.00
10 Spouse + two or more Children	<input type="checkbox"/> \$ 675.00

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/EXPIRATION PERIODS:**

Annual 7/15/2023 to 8/15/2024

**TO CALCULATE YOUR RATE:**

Rate x # of months eligible = amount due      Example: \$226.00 x 3 months = 678.00

**CALCULATION FOR MONTHLY PREMIUM:**

**Monthly premium:** \$ \_\_\_\_\_  
**Multiply by # of months:** \_\_\_\_\_  
**Total premium enclosed:** \$ \_\_\_\_\_

\*PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of 6 months, but not longer than the current Policy Year. Incorrect payment amounts will be returned and no coverage will be in effect.

If the student is still eligible for continuation at the beginning of the next Policy Year, the student must purchase any remaining months of coverage (6 months of coverage less any months of coverage in the previous Policy Year) under the new policy as chosen by the school.

Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. Incorrect payment amounts will be returned and no coverage will be in effect. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 30 days after the expiration date of your previous continuation coverage. If premium is not received within 30 days, the premium will be refunded.

**Payment Instructions:** Make check or money order payable to UnitedHealthcare Student Resources. Mail this enrollment form along with premium payment to:

UnitedHealthcare Student Resources  
 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.

The State of Utah 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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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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"/>	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**

Kwomaroñi bōk jerbāl in jipañ in kajin ilo ejjelōk wōñāñ. Jouj  
im kalōk 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'nida'wo'igii t'áá jíik'eh bee nich'i'  
bee ná'ahoot'i'. T'áá shqódi kohji' 1-866-260-2723 hodiilnih.

**Nepali**

भाषा सहायता सेवाहरू नि:शुल्क उपलब्ध छन्। कृपया  
1-866-260-2723 मा कल गर्नुहोस्।

**Nilotic-Dinka**

Kák ē kuny ajuser ē thok atō tinē yin abac tē cīn wēu yeke  
thiēēc. Yin cōl 1-866-260-2723.

**Norwegian**

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

**Pennsylvania Dutch**

Schprooch iwwesetze Hilf kantscht 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 togotia.  
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.  
Faqlan 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 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**

خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره  
1-866-260-2723 تماس بگیرید.

**Tagalog**

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

**Telugu**

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

**Thai**

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่าย  
แต่อย่างใด 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 anisinis 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 numarayla arayınız.

**Ukrainian**

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

**Urdu**

زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلا معاوضہ دستیاب ہیں۔  
براہ مہربانی 1-866-260-2723 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**

Isẹ ìrànlọ́wọ́ èdè tí ó jẹ ọfẹ́, wà fún ọ. Pe 1-866-260-2723.