



University of Utah 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, aged out of your parent's health insurance plan, marriage, etc.) during the plan year 7/15/2024 to 8/15/2025, you can enroll in the University of Utah 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:

Gender: M F U

Name: _____
(Last name, first name)

Student ID #: _____
(Required)

Birth Date: _____
(mm/dd/yyyy)

Address: _____
(Street, City, State, ZIP)

Email Address: _____ Student Phone #: _____
(Home phone or cell phone)

Enrollment & Payment Instructions:

A QLE is required for primary insureds 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.

Make check or money order payable to UnitedHealthcare Student Resources in US dollars. Mail this completed form, your school injury and sickness insurance enrollment form, required supporting documentation, along with premium payment to: UnitedHealthcare StudentResources; PO Box 809026; Dallas, TX 75380-9026.

Student Signature: _____ Date: _____

For More Information: Contact Kerry Hill at the SHC – kerry.hill@studenthealth.utah.edu or 801-581-5804.

For Administrative Use Only:

Date: _____

Effective Enrollment Period Dates: _____

Approved By: _____

Premium Amount: _____



**UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS**

UNIVERSITY OF UTAH

2024-2310-1

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	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:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> U	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) He/She 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 card; 3) He/She 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 presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Student's Signature _____

Date: _____

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"/>	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

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: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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.

