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 8/1/22 – 7/31/23, 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

Date of Qualifying Life Event: ______________________________________

PRIMARY INSURED
INFORMATION:

Name: ____________________________
(Last name, first name)

Student ID #: ____________________________
(Required)

Birth Date: ____________________________
(mm/dd/yyyy)

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

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

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: ___________________________
Effective Enrollment Period Dates: ___________________________
Approved By: ___________________________
Premium Amount: ___________________________
UNITEDHEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS  
UNIVERSITY OF COLORADO – DENVER INTERNATIONAL  

2022-202710-4

<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>
<th>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).</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE:</td>
<td>GENDER:</td>
</tr>
<tr>
<td>First (Given) Name:</td>
<td>Middle Initial:</td>
</tr>
<tr>
<td>CHILD:</td>
<td>GENDER:</td>
</tr>
<tr>
<td>First (Given) Name:</td>
<td>Middle Initial:</td>
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<td>Middle Initial:</td>
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</table>

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: ____________________
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  
1  Student  ☐ $ 200.00  
2  Spouse / Domestic Partner  ☐ $ 121.00  
3  One Child  ☐ $ 121.00  
4  Two or more Children  ☐ $ 242.00  
5  Spouse and 2 or more Children  ☐ $ 363.00

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 7/31/2023, 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:

<table>
<thead>
<tr>
<th>Rate x # of months eligible = amount due</th>
<th>Example: $200.00 x 3 months = $600.00</th>
</tr>
</thead>
</table>

CALCULATION FOR MONTHLY PREMIUM:

| Monthly premium: $ ________________ |  
| Multiply by # of months: ________________ |  
| Total premium enclosed: $ ________________ |  

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

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.

### Primary Race (select one)
- R1 American Indian / Alaska Native
- R2 Asian
- R3 Black / African American
- R4 Native Hawaiian or other Pacific Islander
- R5 White
- R9 Other (please enter)
- UNKNOWN Unknown / Not Specified

### Secondary Race (select one)
- R1 American Indian / Alaska Native
- R2 Asian
- R3 Black / African American
- R4 Native Hawaiian or other Pacific Islander
- R5 White
- R9 Other (please enter)
- UNKNOWN Unknown / Not Specified

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

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

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<tr>
<th>Code</th>
<th>Ethnicity</th>
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<tbody>
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<td>☐  2165-9</td>
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### Secondary Ethnicity (select one)

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<td>Other (please specify)</td>
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### Primary Language (select one)

<table>
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<tr>
<td>☐  998</td>
<td>Declined</td>
</tr>
<tr>
<td>☐  999</td>
<td>Unavailable</td>
</tr>
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</table>
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)


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 8 p.m. ET.

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

Albanian

Amharic
አማርኛ እንጋገር በክፋል ተፋማፋለ በማይጠቀም ይታወቻ ለክፋል 1-866-260-2723

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

Armenian
Ձեզ կարելի է դառնալ երկրաբանական օժանդակություն համաձայն պատասխան: Բացի դեռևս կարելի է կազմել կապ 1-866-260-2723 համարով.

Bantu-Kirundi

Bisayan-Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengkuwhe nga wallay bayad. Palihih tawag sa 1-866-260-2723.

Bengali-Bangla
যেকোনো ভাষায় সহায়তা পেতে পারেন। ডিএস করে নামান্তরে বাংলা নথিটি আদায় করুন।

Burmese
ကုသည်များနှင့် မော်ယွင်းရေးဆိုင်ရာ အချက်များ ကျင်းပစ်ရန် နိုင်သည်။ 1-866-260-2723

Cambodian-Mon-Khmer
 slightestíptùu tuñkùnuññu kò se hih kò sobhúññu

1-866-260-2723

Cherokee
OOLGAKI, OOLGAKI OOLGAKI H0, RG60794680, RG60794680, RG60794680

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

Chocaw
Chaha anumpa ish anumpil hokmwt toshhbl yvt peh pilla hq chi apela hima. I puya 1-866-260-2723.

Cushite-Oromo
Tajapilluwani garaarsa afarinsa kanfaltu maaile siif jira. Maaloo karsa lakoobsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten 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

German

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

Gujarati
ભાષા સહાયની સેવા તમારા માટે દીદી અપલાડ કરી રીતે 1-866-260-2723 પર ક્રમ કરીને.

Hawaiian
Kaka ʻo makaha ma ka ʻōlelo i loa a ‘ia. E kelepona i ka helu 1-866-260-2723.

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

Hmong
Mhaj cov kev pab thhais lus pub dawb rau koi. Thov hau rau 1-866-260-2723.

Ibo

Ilocano
Adda anaw bayadana a serbisyo para iti language assistance. Pangangalas ita tawagam 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
Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

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

Kurdish Sorani
خۆميزەکانی پەژیمەکانی زەمانییە بەگریزیە بەتۆ دەگەیەن دەکات دەگەیەن. ئەوەیەکان 1-866-260-2723.

Laotian
M蚌ýhì́vàbôa akpàí kàpàít kàpàít tìí kēngà bôx. Šàhìí kàpàít 1-866-260-2723.