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, aged out of your parent’s health insurance plan, marriage, etc.) during the plan year 8/1/2023 – 7/31/2024, 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)

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.

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: ____________________________________________

United Healthcare
### UNITEDHEALTHCARE INSURANCE COMPANY
#### ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
### UNIVERSITY OF COLORADO – DENVER INTERNATIONAL
2023-202710-4

**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>

<table>
<thead>
<tr>
<th>GENDER:</th>
<th>MALE</th>
<th>FEMALE</th>
<th>DATE OF BIRTH: (MONTH/DAY/YEAR)</th>
<th>SCHOOL ID #:</th>
</tr>
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<tbody>
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PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)

<table>
<thead>
<tr>
<th>CITY:</th>
<th>STATE:</th>
<th>ZIP CODE:</th>
<th>TELEPHONE #:</th>
<th>EMAIL ADDRESS:</th>
</tr>
</thead>
<tbody>
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**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).

<table>
<thead>
<tr>
<th>SPOUSE:</th>
<th>GENDER:</th>
<th>MALE</th>
<th>FEMALE</th>
<th>DATE OF BIRTH: (MONTH/DAY/YEAR)</th>
</tr>
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<tbody>
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First (Given) Name: Middle Initial: Last (Family) Name:

<table>
<thead>
<tr>
<th>CHILD:</th>
<th>GENDER:</th>
<th>MALE</th>
<th>FEMALE</th>
<th>DATE OF BIRTH: (MONTH/DAY/YEAR)</th>
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</tr>
</tbody>
</table>

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: ☐ International

<table>
<thead>
<tr>
<th>ID Codes</th>
<th>Monthly (MX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Student</td>
<td>$200.00</td>
</tr>
<tr>
<td>2 Spouse / Domestic Partner</td>
<td>$121.00</td>
</tr>
<tr>
<td>3 One Child</td>
<td>$121.00</td>
</tr>
<tr>
<td>4 Two or more Children</td>
<td>$242.00</td>
</tr>
<tr>
<td>5 Spouse and 2 or more Children</td>
<td>$363.00</td>
</tr>
</tbody>
</table>

INSURED CATEGORY: ☐ English Language Program ☐ Practical Training

<table>
<thead>
<tr>
<th>ID Codes</th>
<th>Monthly (MX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Student</td>
<td>$200.00</td>
</tr>
<tr>
<td>7 Spouse / Domestic Partner</td>
<td>$121.00</td>
</tr>
<tr>
<td>8 One Child</td>
<td>$121.00</td>
</tr>
<tr>
<td>9 Two or more Children</td>
<td>$242.00</td>
</tr>
<tr>
<td>10 Spouse and 2 or more Children</td>
<td>$363.00</td>
</tr>
</tbody>
</table>

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 7/31/2024, 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: $200.00 x 3 months = $600.00

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.

<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>

<table>
<thead>
<tr>
<th>Are you Hispanic/Latino/Spanish:</th>
<th>□ Yes</th>
<th>□ No</th>
<th>□ Unknown</th>
</tr>
</thead>
</table>

<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>
</tr>
<tr>
<td>□ 2169-1 Columbian</td>
<td>□ 2169-1 Columbian</td>
</tr>
<tr>
<td>□ 2182-4 Cuban</td>
<td>□ 2182-4 Cuban</td>
</tr>
<tr>
<td>□ 2184-0 Dominican</td>
<td>□ 2184-0 Dominican</td>
</tr>
<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>
</tr>
<tr>
<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

### 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
Shërbimet e ndihmës në gjithë shqip të tilla një rafinëren e rrë nga filloše. Ju lutem telefononi në numrin 1-866-260-2723.

Amharic
አማርኛ እንጋገር ከማስてしまって ሇ ገንዘቡን ላይ ለማስተካከል እንጋገር 1-866-260-2723 ይወሰሙን ይቻለታል

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

Armenian
2բռ մանր կիրառում երկթիվ օգնության
համար կիրառեն 2բռ մանր գումարվիք 1-866-260-2723 հայերէջ

Bantu-Kirundi
Uronswa ku bantu servisi zifataye ku rurimi zo kugufasha. Utegereza guhugumi 1-866-260-2723.

Bisayan-Visayan (Cebuano)

Bengali-Bangla
সিয়া সাহস পরিষেবা আপনি বিস্তারের প্রেরণা। তাই করুন 1-866-260-2723-তে কল করুন।

Burmese
မြန်မာဘာသာ အောက်ကိုးကွယ်ရေး အား ရရှိနိုင်ရန် အခြေခံမည် 1-866-260-2723 ကိုယ်လျော်စွာ

Cambodian-Mon-Khmer
សុខប្រាក់ជាមួយអត្ថបទនៃសេចក្តីប្រការដ៏អស្ចេង 1-866-260-2723 សូមចូលបាន។

Cherokee
SOWOOLJO OPOLEAJI OPOYET HO RG667 1HO/LKJ7 IR6EG7O 1DO 1KGE DHEO 1B9Y 1-866-260-2723.

Chinese
您可以免费获得语言援助服务，联系电话 1-866-260-2723。

Chocatw
Chaha anampa ish anumpuli hokmwt toshboli yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite-Oromo
Tajajillawwan gargaarsa afaarni kanfalttu malee siif jira. Maalo karaa laakoosaa bilbilaa 1-866-260-2723 bilbilii.

Dutch
Taalbijstandsdiens ten 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 διαθέτουν δωρεάν. Καλωσήρετε το 1-866-260-2723.

Gujarati
અમાન સહસ સેવાઓ તમાર માટે હું માટ ઉપલબ્ધ છે. હેઠળ ક્રમે કરીને 1-866-260-2723 પર કેલ કરશે.

Hawaiian
Kōksa mamahī ma kāu 'olelo i lōa 'ia. E kelepona i ka helu 1-866-260-2723.

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

Hmong
Mhaj cov kev pab tohais hau pub dawb rau koi. Thow hau rau 1-866-260-2723.

Ibo

Ilocano
Adda awan bayadana a serbisyo para iti language assistance. Punggassim ta 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
สิ่งที่มีคุณภาพที่จะช่วยให้คุณเข้าถึงบริการโดยไม่เสียค่าใช้จ่าย 1-866-260-2723.

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

Kru-Bassa
Bot ba hola ni kobol mahop ngui nsan wogui wo ba ye ha i nyu yiop. Sebel i nsinga ini 1-866-260-2723.

Kurkish
Sorani
خزمه گیتکایی پارامیزی زمانی بیانی چیت آنجین دیروج کین. دیکبات دایونز کی به یک زبان ترکی، 1-866-260-2723.

Laotian
มีบริการสนับสนุนภาษาที่สามารถให้ความช่วยเหลือ หมายเลข 1-866-260-2723.