



Virginia Commonwealth University

Qualifying Life Event Request

Nature of Your Qualifying Event:

If you experience a Qualifying Life Event (QLE) (e.g. loss of health insurance coverage, aged out of your parent's health insurance, marriage, etc.) during the plan year 8/15/2023 - 8/14/2024, you can enroll in the Virginia Commonwealth University 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

Name: _____
(Last name, first name)

Student ID #: _____
(Required)

Birth Date: _____
(mm/dd/yyyy)

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

Student Phone #: _____ Email Address: _____
(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 supporting documentation 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: Contact Customer Service at 1-866-589-1050.

For Administrative Use Only:

Date: _____

Effective Enrollment Period Dates: _____

Approved By: _____

Premium Amount: _____

UNITEDHEALTHCARE INSURANCE COMPANY
 QUALIFYING LIFE EVENT ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

VIRGINIA COMMONWEALTH UNIVERSITY

2023-121-1

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	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	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 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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company.

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:**
- | | |
|--|--|
| <input type="checkbox"/> Dentistry 1 st Year - D1 | <input type="checkbox"/> Dentistry 2 nd Year - D2 |
| <input type="checkbox"/> Dentistry 3 rd Year - D3 | <input type="checkbox"/> Dentistry 4 th Year - D4 |

- | | |
|---------------------------------|------------------------------------|
| ID Codes | Monthly (MX) |
| 1 Student | <input type="checkbox"/> \$ 222.00 |
| 2 Spouse | <input type="checkbox"/> \$ 222.00 |
| 3 One Child | <input type="checkbox"/> \$ 222.00 |
| 4 Two or more Children | <input type="checkbox"/> \$ 444.00 |
| 5 Spouse and 2 or more Children | <input type="checkbox"/> \$ 666.00 |

PLEASE CHECK ALL APPROPRIATE BOXES.

- INSURED CATEGORY:**
- | | |
|--|--|
| <input type="checkbox"/> Medical 1 st Year - M1 | <input type="checkbox"/> Medical 2 nd Year - M2 |
| <input type="checkbox"/> Medical 3 rd Year - M3 | <input type="checkbox"/> Medical 4 th Year - M4 |

- | | |
|----------------------------------|------------------------------------|
| ID Codes | Monthly (MX) |
| 6 Student | <input type="checkbox"/> \$ 222.00 |
| 7 Spouse | <input type="checkbox"/> \$ 222.00 |
| 8 One Child | <input type="checkbox"/> \$ 222.00 |
| 9 Two or more Children | <input type="checkbox"/> \$ 444.00 |
| 10 Spouse and 2 or more Children | <input type="checkbox"/> \$ 666.00 |

PLEASE CHECK ALL APPROPRIATE BOXES.

- INSURED CATEGORY:**
- | | |
|---|---|
| <input type="checkbox"/> Pharmacy 1 st Year - P1 | <input type="checkbox"/> Pharmacy 2 nd Year - P2 |
| <input type="checkbox"/> Pharmacy 3 rd Year - P3 | <input type="checkbox"/> Pharmacy 4 th Year - P4 |

- | | |
|----------------------------------|------------------------------------|
| ID Codes | Monthly (MX) |
| 11 Student | <input type="checkbox"/> \$ 222.00 |
| 12 Spouse | <input type="checkbox"/> \$ 222.00 |
| 13 One Child | <input type="checkbox"/> \$ 222.00 |
| 14 Two or more Children | <input type="checkbox"/> \$ 444.00 |
| 15 Spouse and 2 or more Children | <input type="checkbox"/> \$ 666.00 |

PLEASE CHECK ALL APPROPRIATE BOXES.

- INSURED CATEGORY:** PhD

- | | |
|----------------------------------|------------------------------------|
| ID Codes | Monthly (MX) |
| 16 Student | <input type="checkbox"/> \$ 222.00 |
| 17 Spouse | <input type="checkbox"/> \$ 222.00 |
| 18 One Child | <input type="checkbox"/> \$ 222.00 |
| 19 Two or more Children | <input type="checkbox"/> \$ 444.00 |
| 20 Spouse and 2 or more Children | <input type="checkbox"/> \$ 666.00 |

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: International

- | | |
|----------------------------------|------------------------------------|
| ID Codes | Monthly (MX) |
| 21 Student | <input type="checkbox"/> \$ 222.00 |
| 22 Spouse | <input type="checkbox"/> \$ 222.00 |
| 23 One Child | <input type="checkbox"/> \$ 222.00 |
| 24 Two or more Children | <input type="checkbox"/> \$ 444.00 |
| 25 Spouse and 2 or more Children | <input type="checkbox"/> \$ 666.00 |

EFFECTIVE/EXPIRATION PERIODS:

Annual 8/15/2023 to 8/14/2024

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: \$222.00 x 3 months = \$666.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: \$ _____

Multiply by # of months: _____

Total premium enclosed: \$ _____

The Virginia Health Information Organization requests the following information about the Primary Insured. If you choose not to provide this information, please select the appropriate box below.

I have read the request for information and choose not to supply a response.

Primary Race (select one)			Secondary Race (select one)		
<input type="checkbox"/>	R1	American Indian / Alaska Native	<input type="checkbox"/>	R1	American Indian / Alaska Native
<input type="checkbox"/>	R2	Asian	<input type="checkbox"/>	R2	Asian
<input type="checkbox"/>	R3	Black / African American	<input type="checkbox"/>	R3	Black / African American
<input type="checkbox"/>	R4	Native Hawaiian or other Pacific Islander	<input type="checkbox"/>	R4	Native Hawaiian or other Pacific Islander
<input type="checkbox"/>	R5	White	<input type="checkbox"/>	R5	White
<input type="checkbox"/>	R9	Other (please enter)	<input type="checkbox"/>	R9	Other (please enter)
<input type="checkbox"/>	UNKNOWN	Unknown / Not Specified	<input type="checkbox"/>	UNKNOWN	Unknown / Not Specified

Are you Hispanic/Latino/Spanish: Yes No Unknown

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

Primary Ethnicity (select one)			Secondary Ethnicity (select one)		
<input type="checkbox"/>	2165-9	South American (not otherwise specified)	<input type="checkbox"/>	2165-9	South American (not otherwise specified)
<input type="checkbox"/>	2047-9	Vietnamese	<input type="checkbox"/>	2047-9	Vietnamese
<input type="checkbox"/>	OTHER	Other (please specify)	<input type="checkbox"/>	OTHER	Other (please specify)
<input type="checkbox"/>	UNKNOWN	Unknown / Not Specified	<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 <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.

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

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic

የቋንቋ ለርዳታ አገልግሎቶች በነጻ ይሰጣሉ። ለበክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic

توفر تلك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ մատչելի են անվճար լեզվալսման օգնությունն հայերենի և անգլերենի: Խնդրում ենք զանգահարել 1-866-260-2723 համայնով:

Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်ပါသည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមអ្នកសុំទៅលេខ 1-866-260-2723។

Cherokee

ᏈᏊᏌᏉᏍᏉᏗ ᏃᏂᏍᏉᏍᏉᏗ ᏃᏂᏍᏉᏍᏉᏗ ᏌᏃ ᏂᏍᏉᏍᏉᏗᏉᏍᏉᏗ ᏌᏃᏍᏉᏍᏉᏗ ᏃᏂᏍᏉᏍᏉᏗ 1-866-260-2723.

Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw

Chahta anumpa ish anumpuli hokmyt tohsholi yvt peh pilla hᏍ chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfaltii malee siif jira. Maaloo karaa lakkoofsa 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

Gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek

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

Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

Hawaiian

Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

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

ကျိတ်တိတိ ဝေဒါနုကုန်ဆီ သုခိလတတဒိဒိ:ကျိတ်တိတိ(ဒိတ်တိ)ကျိတ်တိ. ဝေဒါနုကုန်ဆီ: 1-866-260-2723 ဝေဒါနု.

Korean

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

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba ye ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمەتگێڕی یارمەتی زانی بەخۆڕ بی یۆ ئۆ دایین دەرکێن. تەکلە تەمبۆر. یەکە یۆ زۆمانی. 1-866-260-2723.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃບຫາເບີ 1-866-260-2723.

