



Georgia State University 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 August 1, 2023 - July 31, 2024 you can enroll in the Georgia State 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.

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

To pay with a credit card: If you want to pay for your coverage with or eCheck, email this completed form, your school injury and sickness insurance enrollment form, required supporting documentation, to SIDPremium-CustomerService@uhcsr.com or fax it to 469-229-5612. Make sure your email address is correct as we will enter your coverage request into our system and send you an email message with instructions for making your premium payment online with a credit card or eCheck.

Student Signature: _____ Date: _____

FOR MORE INFORMATION: Call customer service at 1-866-403-8267.

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

GEORGIA STATE UNIVERSITY

2023-201-4

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) 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 card; 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/School Attending: _____

Please print name of University. Must be completed in order for application to be processed.

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

- | | |
|---------------------------------|------------------------------------|
| ID Codes | Monthly (MX) |
| 1 Student | <input type="checkbox"/> \$ 238.00 |
| 2 Spouse | <input type="checkbox"/> \$ 262.00 |
| 3 One Child | <input type="checkbox"/> \$ 262.00 |
| 4 Two or more Children | <input type="checkbox"/> \$ 524.00 |
| 5 Spouse and 2 or more Children | <input type="checkbox"/> \$ 786.00 |

TO CALCULATE YOUR RATE:

Rate x# of months eligible = amount due
Example: \$238.00 x 3 months = \$714.00

Please multiply the rate and number of days and/or months to get your total premium.	
Student	\$238.00 x _____ months = \$ _____
Spouse	\$262.00 x _____ months = \$ _____
One Child	\$262.00 x _____ months = \$ _____
Two or More Children	\$524.00 x _____ months = \$ _____
Spouse and 2 or More Children	\$786.00 x _____ months = \$ _____
Total	\$ _____

** Please note: premiums are cumulative (Ex. Student + Spouse = Total premium due).

Requested Effective Date: _____ / _____ / _____	Termination Date: 7/31/2024
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Payment Instructions: Make check or money order payable to UnitedHealthcare Student Resources in US dollars. 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.

HOW TO ENROLL OR PAY ONLINE

Online Enrollment:

If your school allows online enrollment and you would like to purchase your coverage using a credit card or eCheck, please visit www.uhcsr.com/gsu. You can search for your school, choose your plan, and click on EXPLORE POLICY to review plan documents. To purchase coverage, click on ENROLL NOW and follow the on screen prompts to complete your enrollment.

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.

Marathi

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे.
त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Kwomaroŋi bōk jerbāl in jipañ in kajin ilo ejjelōk wōpāñ. Jouj
im kallōk 1-866-260-2723.

Micronesian- Pohnpeian

Mic sawas en mahsen ong komwi, soh isepc. Melau eker
1-866-260-2723.

Navajo

Saad bee áka'e'eyeed bee áka'nida'wo'igfi t'áá jiik'eh bee nich'i
bee ná'ahoof'i. T'áá shōqdi 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 ajueer ē thok atō timē yin abac tē cin wēu yeke
thiēc. Yin cōl 1-866-260-2723.

Norwegian

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

Pennsylvania Dutch

Schprooch iwweetze 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 lo maua fesoasoani mo gagana mo oe ma e le totogia.
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.
Fadlan 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

Bi 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

ܠܗܘܢܘܫܐ ܕܥܘܠܡܐ ܕܡܫܝܚܐ ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ
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1-866-260-2723 ܕܥܝܪܐܢܐ ܕܥܝܪܐܢܐ

Tagalog

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

Telugu

భాషా సహాయం అందించే సేవలు 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 aninisin 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 numaramı 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۔
برہ 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 אוועקגעבן פאר אײך פריי פון אפצאל. ביטע
1-866-260-2723 וואס.

Yoruba

Isẹ̀ lóránlọ̀wọ̀ èdè tí ọ̀ jẹ́ ọ̀fẹ́, wà fún ọ̀. Pe 1-866-260-2723.