

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
ENROLLMENT FORM FOR DEPENDENTS



STATE UNIVERSITY OF NEW YORK

2023-203415-41

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) 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: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation..

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

TOTAL PLAN COST: The Total Cost of the plan includes the insurance premium and additional fees. See the table below for the breakdown of the insurance premium and fees. **Please remit the Total Plan Cost.**

ID Codes	Annual (A-)	Fall (F-)	Spring (G-)
2 Spouse	<input type="checkbox"/> \$ 2,320.00	<input type="checkbox"/> \$ 969.84	<input type="checkbox"/> \$ 963.50
3 One Child	<input type="checkbox"/> \$ 2,320.00	<input type="checkbox"/> \$ 969.84	<input type="checkbox"/> \$ 963.50
4 Two or more Children	<input type="checkbox"/> \$ 4,640.00	<input type="checkbox"/> \$ 1,939.68	<input type="checkbox"/> \$ 1,927.00
5 Spouse and Two or more Children	<input type="checkbox"/> \$ 6,960.00	<input type="checkbox"/> \$ 2,909.52	<input type="checkbox"/> \$ 2,890.50

ID Codes	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
2 Spouse	<input type="checkbox"/> \$ 1,350.16	<input type="checkbox"/> \$ 583.17	<input type="checkbox"/> \$ 193.33	<input type="checkbox"/> \$ 101.42
3 One Child	<input type="checkbox"/> \$ 1,350.16	<input type="checkbox"/> \$ 583.17	<input type="checkbox"/> \$ 193.33	<input type="checkbox"/> \$ 101.42
4 Two or more Children	<input type="checkbox"/> \$ 2,700.32	<input type="checkbox"/> \$ 1,166.34	<input type="checkbox"/> \$ 386.66	<input type="checkbox"/> \$ 202.84
5 Spouse and Two or more Children	<input type="checkbox"/> \$ 4,050.48	<input type="checkbox"/> \$ 1,749.51	<input type="checkbox"/> \$ 579.99	<input type="checkbox"/> \$ 304.26

INSURANCE PLAN PREMIUM: The premium below is for the insurance coverage underwritten by UnitedHealthcare Insurance Company of New York and does not include additional fees charged to you to enroll in the Student Health Plan. Refer to the bullet(s) below the table for details on the fees added to the premium to equal the Total Plan Cost. Please remit the Total Plan Cost from the table above.

	Annual (A-)	Fall (F-)	Spring (G-)
Spouse	\$ 2,317.62	\$ 968.85	\$ 962.51
One Child	\$ 2,317.62	\$ 968.85	\$ 962.51
Two or more Children	\$ 4,635.24	\$ 1,937.70	\$ 1,925.02
Spouse and Two or more Children	\$ 6,952.86	\$ 2,906.55	\$ 2,887.53

	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
Spouse	\$ 1,348.77	\$ 582.57	\$ 193.13	\$ 101.32
One Child	\$ 1,348.77	\$ 582.57	\$ 193.13	\$ 101.32
Two or more Children	\$ 2,697.54	\$ 1,165.14	\$ 386.26	\$ 202.64
Spouse and Two or more Children	\$ 4,046.31	\$ 1,747.71	\$ 579.39	\$ 303.96

Additional Fees: The fees are prorated for coverage periods other than annual.

- Annual Service fee of \$2.38 for UHC Global administration of the Assistance and Evacuation Benefits.

EFFECTIVE/EXPIRATION PERIODS:

- Annual 8/15/2023 to 8/14/2024
- Fall 8/15/2023 to 1/14/2024
- Spring 1/15/2024 to 6/14/2024
- Spring/Summer 1/15/2024 to 8/14/2024
- Summer 5/15/2024 to 8/14/2024

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Monthly coverage expires 1 month following receipt of your premium or 8/14/2024, 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: \$193.33 x 3 months = \$579.99

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 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.

The State of New York requires UnitedHealthcare Insurance Company of New York to request the following information about the Donate Life Registry. You must fill out the following section.

Would you like to be added to the Donate Life Registry?

Check box for 'yes' or 'skip this question'. Yes Skip this question

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 አርዳታ አገልግሎቶች በነጻ ይኖራሉ። አባከዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ մատչելի են անվճար լեզվաբանական օգնությունները Ծանայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

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

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

Burmese

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

Cambodian- Mon-Khmer

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

Cherokee

ᏌᏊᏃᏉᏂᏎᏉ ᏡᏐᏂᏎᏊᏎᏎ ᏡᏐᏂᏎᏊᏎ ᏃᏊ ᏒᏃᏉᏉᏉᏉᏉᏉᏉᏉᏉᏉᏉ ᏃᏊᏃᏊᏃᏊᏃᏊᏃᏊᏃᏊ ᏃᏊᏃᏊᏃᏊᏃᏊᏃᏊᏃᏊ 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 hokmvt tohsholi yvt peh pilla ho 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

Taalbijstanddiensten 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 èd 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 ‘ōlelo i loa‘a ‘ia. 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

ကိုရိုတ်ခါၤဖၤအနီၣ်န့ၣ်မုၢ်ခါၤသ့ၣ်လၢတတံၣ်ယုၣ်ခဲၣ်န့ၣ်တုၢ် (ခိၣ်)န့ၣ်တုၢ်။ တံၤဆူၤဆဲးကိုးတုၢ် 1-866-260-2723 တက့ၢ်။

Korean

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

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaawogui wo ba yé ha i nyuuyonj. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمهنگانی یارمەتی زمانی بـهـخـۆـرـایـی بـۆ تـۆ دابـین دـهـکـرـێـن. تـکایـه تـهـمـهـنـهـرـێـن بـهـ بـۆ ژماره‌ی 1-866-260-2723.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃບທາງດັບ 1-866-260-2723.

