

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK  
ENROLLMENT FORM FOR DEPENDENTS



STATE UNIVERSITY OF NEW YORK

2023-203415-43

<b>PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.</b>		
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:	

<b>DEPENDENT INFORMATION</b>		
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:**  Study Abroad

**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"/> \$ 686.00	<input type="checkbox"/> \$ 286.77	<input type="checkbox"/> \$ 284.90
3 One Child	<input type="checkbox"/> \$ 686.00	<input type="checkbox"/> \$ 286.77	<input type="checkbox"/> \$ 284.90
4 Two or more Children	<input type="checkbox"/> \$ 1,372.00	<input type="checkbox"/> \$ 573.54	<input type="checkbox"/> \$ 569.80
5 Spouse and Two or more Children	<input type="checkbox"/> \$ 2,058.00	<input type="checkbox"/> \$ 860.31	<input type="checkbox"/> \$ 854.70

ID Codes	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
2 Spouse	<input type="checkbox"/> \$ 399.23	<input type="checkbox"/> \$ 172.44	<input type="checkbox"/> \$ 57.17	<input type="checkbox"/> \$ 29.99
3 One Child	<input type="checkbox"/> \$ 399.23	<input type="checkbox"/> \$ 172.44	<input type="checkbox"/> \$ 57.17	<input type="checkbox"/> \$ 29.99
4 Two or more Children	<input type="checkbox"/> \$ 798.46	<input type="checkbox"/> \$ 344.88	<input type="checkbox"/> \$ 114.34	<input type="checkbox"/> \$ 59.98
5 Spouse and Two or more Children	<input type="checkbox"/> \$ 1,197.69	<input type="checkbox"/> \$ 517.32	<input type="checkbox"/> \$ 171.51	<input type="checkbox"/> \$ 89.97

**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	\$ 683.62	\$ 285.78	\$ 283.91
One Child	\$ 683.62	\$ 285.78	\$ 283.91
Two or more Children	\$ 1,367.24	\$ 571.56	\$ 567.82
Spouse and Two or more Children	\$ 2,050.86	\$ 857.34	\$ 851.73

	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
Spouse	\$ 397.84	\$ 171.84	\$ 56.97	\$ 29.89
One Child	\$ 397.84	\$ 171.84	\$ 56.97	\$ 29.89
Two or more Children	\$ 795.68	\$ 343.68	\$ 113.94	\$ 59.78
Spouse and Two or more Children	\$ 1,193.52	\$ 515.52	\$ 170.91	\$ 89.67

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_.

<b>TO CALCULATE YOUR RATE:</b>
Rate x # of months eligible = amount due      Example: \$57.17 x 3 months = \$171.51
<b>CALCULATION FOR MONTHLY PREMIUM:</b>
Monthly premium: \$ _____
Multiply by # of months: _____
Total premium enclosed: \$ _____
<b>Payment Instructions:</b> 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](mailto: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**

Kwमारोñ bōk jerbāl in jipañ in kajin ilo ejjelōk wōñāñ. Jouj  
im kalloḷ 1-866-260-2723.

**Micronesian- Pohnpeian**

Mie sawas en mahsen ong komwi. soh isepe. Melau eker  
1-866-260-2723.

**Navajo**

Saad bee aka'e'eyeed bee aka'nida'wo'igii t'aa jii'k'eh bee nich'i'  
bee na'ahoot'i. T'aa shooḍi kohji' 1-866-260-2723 hodiilnih.

**Nepali**

भाषा सहायता सेवाहरू नि:शुल्क उपलब्ध छन्। कृपया  
1-866-260-2723 मा कल गर्नुहोस्।

**Nilotic-Dinka**

Kāk ē kuny ajuer ē thok atō tñē yīn abac tē cīn wēu yeke  
thiēc. Yīn cōl 1-866-260-2723.

**Norwegian**

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

**Pennsylvania Dutch**

Schprooch iwwesetze 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. Zadzwon  
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 dispozitie, 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 loo maua fesoasoani mo gagana mo oe ma e lē tologia.  
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.  
Faadlan 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**

E woodi walliinde dow wolde caahu ngam maada. Noodu  
1-866-260-2723.

**Swahili**

Huduma za msaaada wa lugha zinapatikana kwa ajili yako bure.  
Tafadhali piga simu 1-866-260-2723.

**Syriac- Assyrian**

ܩܘܨܬܐ ܕܘܫܬܪܐܢܐ ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ  
ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ ܕܘܨܬܪܐܢܐ  
1-866-260-2723

**Tagalog**

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

**Telugu**

అంకియత అసిస్టియంట్ సర్వీస్ మికు ఉచితంగా అందుబాటులో ఉన్నాయి.  
దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

**Thai**

บริการการความช่วยเหลือด้านภาษาให้โดยที่คคุณไม่ต้องเสียค่าใช้จ่าย  
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 yardim hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen  
1-866-260-2723 numarayı 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۔  
براہ 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**

שראך הילף סערוויסעס זענען אוועקגעבן פאר אייך פריי פון אפצאלן. ביטע  
רופע 1-866-260-2723.

**Yoruba**

Isẹ iranlọwọ èdè tí ń jẹ́ ọfẹ́, wà fún ọ. Pe 1-866-260-2723.