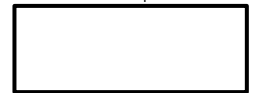


UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
ENROLLMENT FORM FOR DEPENDENTS



STATE UNIVERSITY OF NEW YORK

2019-203415-41

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	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 prorated 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"/> \$ 1,329.00	<input type="checkbox"/> \$ 554.00	<input type="checkbox"/> \$ 552.00
3 One Child	<input type="checkbox"/> \$ 1,329.00	<input type="checkbox"/> \$ 554.00	<input type="checkbox"/> \$ 552.00
4 Two or more Children	<input type="checkbox"/> \$ 2,658.00	<input type="checkbox"/> \$ 1,108.00	<input type="checkbox"/> \$ 1,104.00
5 Spouse + two or more Children	<input type="checkbox"/> \$ 3,987.00	<input type="checkbox"/> \$ 1,662.00	<input type="checkbox"/> \$ 1,656.00

ID Codes	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
2 Spouse	<input type="checkbox"/> \$ 775.00	<input type="checkbox"/> \$ 334.00	<input type="checkbox"/> \$ 111.00	<input type="checkbox"/> \$ 58.00
3 One Child	<input type="checkbox"/> \$ 775.00	<input type="checkbox"/> \$ 334.00	<input type="checkbox"/> \$ 111.00	<input type="checkbox"/> \$ 58.00
4 Two or more Children	<input type="checkbox"/> \$ 1,550.00	<input type="checkbox"/> \$ 668.00	<input type="checkbox"/> \$ 222.00	<input type="checkbox"/> \$ 116.00
5 Spouse + two or more Children	<input type="checkbox"/> \$ 2,325.00	<input type="checkbox"/> \$ 1,002.00	<input type="checkbox"/> \$ 333.00	<input type="checkbox"/> \$ 174.00

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	\$ 1,326.62	\$ 553.01	\$ 551.01
One Child	\$ 1,326.62	\$ 553.01	\$ 551.01
Two or more Children	\$ 2,653.24	\$ 1,106.02	\$ 1,102.02
Spouse + two or more Children	\$ 3,979.86	\$ 1,659.03	\$ 1,653.03

	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
Spouse	\$ 773.61	\$ 333.40	\$ 110.80	\$ 58.00
One Child	\$ 773.61	\$ 333.40	\$ 110.80	\$ 58.00
Two or more Children	\$ 1,547.22	\$ 666.80	\$ 221.80	\$ 116.00
Spouse + two or more Children	\$ 2,320.83	\$ 1,000.20	\$ 332.80	\$ 174.00

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 8/15/2019 to 8/14/2020
 Fall 8/15/2019 to 1/14/2020
 Spring 1/15/2020 to 6/14/2020
 Spring/Summer 1/15/2020 to 8/14/2020
 Summer 5/15/2020 to 8/14/2020

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 8/14/2020, 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: \$111.00 x 3 months = \$333.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: \$ _____

Multiply by # of months: _____

Total premium enclosed: \$ _____

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. Mail this enrollment form along with premium payment to:

UnitedHealthcare **StudentResources**
 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.

Dependents Only:

If the primary insured purchases coverage through their school, they can request to be notified when dependent coverage is available to purchase once the primary insured's coverage is in force. To complete this request, visit uhcsr.com/control and select "Notify me" and complete the form. Once the primary insured's coverage is in force, a notification email will be sent indicating that dependent coverage can be purchased.

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

የድንገት ለርዳታ አገልግሎቶች በነጻ ይገኛሉ። 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 լեզվական օգնությունը և ծառայությունները: 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- Bangla

সহাযতা : 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។ សូមផ្ញើសំណុំទៅលេខ 1-866-260-2723។

Cherokee

ᏍᏌᏂᏁᏓᏂᏛ ᏓᏍᏂᏛᏂᏛ ᏓᏍᏂᏛᏂᏛ ᏁᏃ ᐱᏂᏛᏂᏛᏛᏛᏛ ᏁᏃᏂᏛᏛᏛᏛ ᏁᏃᏂᏛᏛᏛᏛᏛ ᏁᏃᏂᏛᏛᏛᏛᏛ 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

Tajaajilliiwwan gargaarsa afaanii kanfalttii 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 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 સહાયત્વા 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 wawagam 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

ကျိက်တဲးမၤစၢၤအကိုးန့ၢ်အိၣ်အသ့လၢတဲလိၣ်ဟ့ၣ်အပူၤဘၣ်(ခိၣ်)န့ၣ်လီၤ. ဝံးဆူၤဆဲးကျိၣ်ဘၣ် 1-866-260-2723တက့ၢ်.

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 ye ha i nyuu yonj. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمتهكاتی یارمەتی زمانی بەخۆرایی بۆ تۆ دابین دەکرین. تکایە تەلەفۆن بکە بۆ ژمارە 1-866-260-2723.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃບທາດບີ 1-866-260-2723.

Marathi

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

Marshallese

Kwomaroñ bōk jerbāl in jipañ in kajin ilo ejjelōk wōñāān. Jouj
im kallōk 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'eh bee nich'i'
bee na'ahoot'i'. T'aa' shōqdi kohji' 1-866-260-2723 hodiilnih.

Nepali

भाषा सहायता सेवाहरू निःशुल्क 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
thiēēc. Yīn cōl 1-866-260-2723.

Norwegian

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

Pennsylvania Dutch

Schprooch iwwesetze Hilf kannscht 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 loo maua fesoasoani mo gagana mo oe ma e lē 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

E 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

ܠܗܘܢܘܫܝܘܬܝܢ ܕܡܫܘܥܬܝܢ ܕܡܫܘܥܬܝܢ ܕܡܫܘܥܬܝܢ ܕܡܫܘܥܬܝܢ
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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

అంకిక్ష్ణ్ అసిస్ట్వంట్ సర్వీస్స్ 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 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

שפראך הילף סערוויסעס זענען אוועילעבאר פאר אײך פריי פון אפצאל. ביטש
רופט 1-866-260-2723.

Yoruba

Isẹ iranlọwọ èdè tí ó jẹ òfẹ́, wà fún ọ. Pe 1-866-260-2723.