



University of Mississippi

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, aged out of your parent's health insurance, marriage, etc.) during the plan year 8/15/24-8/14/25, you can enroll in the University of Mississippi 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)

United
Healthcare®

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 in US dollars. 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 or eCheck: Email this completed form and your school injury and sickness insurance enrollment form 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: Call 1-800-980-4698.

For Administrative Use Only:

Date: _____

Effective Enrollment Period Dates: _____

Approved By: _____

Premium Amount: _____



UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF MISSISSIPPI

2024-515-1

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) 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 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: _____

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: Graduate Assistant

ID Codes	Monthly (MX)
6 Student	<input type="checkbox"/> \$ 193.00
7 Spouse	<input type="checkbox"/> \$ 193.00
8 One Child	<input type="checkbox"/> \$ 193.00
9 Two or more Children	<input type="checkbox"/> \$ 386.00
10 Spouse and 2 or more Children	<input type="checkbox"/> \$ 579.00

EFFECTIVE/EXPIRATION PERIODS:

Annual 8/15/2024 to 8/14/2025

TO CALCULATE YOUR RATE:

Rate x# of months eligible = amount due Example: \$193.00 x 3 months = \$579.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: \$ _____

Multiply by # of months: _____

Total premium enclosed: \$ _____

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: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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.

