



Kennesaw 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, 2024 - July 31, 2025 you can enroll in the Kennesaw 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
U

Name: _____
(Last name, first name)

Student ID #: _____
(Required)

Birth Date: _____
(mm/dd/yyyy)

Address: _____
(Street, City, State, ZIP)

Email Address: _____ Student Phone #: _____
(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.

Voluntary Enrollment Students: Fill out this QLE request and submit it along with supporting documentation, a completed enrollment form, and premium payment to UnitedHealthcare Student Resources; PO Box 809026; Dallas, TX 75380-9026. If you want to pay for your coverage with a credit card or eCheck, email your enrollment form 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.

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 1-866-403-8267 or Email info@uhcsr.com.

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

KENNESAW STATE UNIVERSITY

2024-599-11

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 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: Graduate Practical Training
 Undergraduate

ID Codes	Monthly (MX)
1 Student	<input type="checkbox"/> \$ 343.00
2 Spouse	<input type="checkbox"/> \$ 378.00
3 One Child	<input type="checkbox"/> \$ 378.00
4 Two or more Children	<input type="checkbox"/> \$ 756.00
5 Spouse and 2 or more Children	<input type="checkbox"/> \$ 1,134.00

TO CALCULATE YOUR RATE:
 Rate x# of months eligible = amount due
 Example: \$343.00 x 3 months = \$1,029.00

Please multiply the rate and number of days and/or months to get your total premium.	
Student	\$343.00 x ____ months = \$ _____
Spouse	\$378.00 x ____ months = \$ _____
One Child	\$378.00 x ____ months = \$ _____
Two or More Children	\$756.00 x ____ months = \$ _____
Spouse and 2 or More Children	\$1,134.00 x ____ months = \$ _____
Total	\$ _____

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

Requested Effective Date: ____ / ____ / ____	Termination Date: 7/31/2025
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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/kennesaw. 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: <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.

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.

Ambharic

የደንበኞች ለርዳታ አገልግሎቶች በነጻ ይገኛሉ። ለሰነድ ወደ 1-866-260-2723 ይደውሉ።

Arabic

توفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ անսղեխ են անվճար լեզվալսյան օգնությունները։ Կոչում ենք Ձեր զանգահարել 1-866-260-2723 համարով։

Bantu- Kirundi

Uronswa ku buntu serivisi zifatye 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

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

Burmese

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

Cambodian- Mon-Khmer

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

Cherokee

ᄀᄇᄆᄋᄊ ᄀᄇᄆᄋᄊ ᄀᄇᄆᄋᄊ ᄆᄋᄇᄆᄇ ᄆᄋᄇᄆᄇ ᄆᄋᄇᄆᄇ ᄆᄋᄇᄆᄇ ᄆᄋᄇᄆᄇ ᄆᄋᄇᄆᄇ ᄆᄋᄇᄆᄇ 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 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 ed 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 ʻōlelo i loaʻa ʻia. 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

တိုက်ခိုက်မှုအန္တရာယ်များရှိသောနယ်မြေများတွင် အကူအညီအတွက် (နိုင်ငံ) နှင့် ဝေးကွာသွားတိုက်ခိုက်မှု 1-866-260-2723 သို့ ခေါ်ဆိုပါ။

Korean

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

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba ye ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمەتگێڕی یارمەتیی زمانی بەخۆڕ یی بۆ تۆ داڵین دەرکری. نەکیه تەلەفۆن بەکە بز 1-866-260-2723 ژمارەیی.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃບທາງ 1-866-260-2723.

Marathi

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

Marshallese

Kwomaroñi bōk jerbal 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'ahoo'fi. T'áá shōqdi kohji' 1-866-260-2723 hodiilnih.

Nepali

भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया
1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka

Kák ē kuny ajuer ē thok atō tñē 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 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 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 lo 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

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

ܠܚܘܒܝܢܘܬܐ ܕܘܫܩܘܬܐ ܕܝܡܘܨܝܪܝܬܐ ܕܝܢܘܨܝܪܝܬܐ ܕܝܥܘܪܝܢܝܘܬܐ
ܕܝܥܘܪܝܢܝܘܬܐ ܕܝܥܘܪܝܢܝܘܬܐ ܕܝܥܘܪܝܢܝܘܬܐ ܕܝܥܘܪܝܢܝܘܬܐ ܕܝܥܘܪܝܢܝܘܬܐ
1-866-260-2723

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 అందించడానికి సర్వీసును మీకు ఉచితంగా అందించాము. ఈ సహాయం
1-866-260-2723 కి కాల్ చేయండి.

Thai

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คนไทยต้องเสียค่าใช้จ่าย
แต่อย่างไร โปรดโทรติดต่อถึงหมายเลข
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 کل 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 פֿרײַ פֿון אפּצאל. ביטע
רופ 1-866-260-2723.

Yoruba

Isẹ̀ lánlọ̀wọ̀ èdè ti ó jẹ́ òfẹ́, wá fún ọ̀. Pe 1-866-260-2723.