Rhodes College
Qualifying Life Event Request

If you experience a Qualifying Life Event (QLE) during the plan year (08/01/2024 - 07/31/2025), you can enroll in the Rhodes College student health insurance plan (SHIP) for the remainder of the current coverage period. To request a QLE enrollment, please complete this form, sign and date it.

Reason for QLE:

- ☐ Loss of coverage under another plan
- ☐ Change in marital status
- ☐ Adoption of a child/birth of a child
- ☐ Guardianship appointment
- ☐ International Students: arrival of spouse/dependents in country
- ☐ Other (please explain) _____

Date of QLE: _____

Primary Insured Information: Gender: ☐ M ☐ F

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 and 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.

To qualify for a QLE enrollment, one of the following documents must be submitted:

- Certificate of prior health coverage
- Marriage certificate
- Birth certificate or adoption papers
- Guardianship appointment papers
- International students: flight itinerary showing date of arrival in country

Student Signature: _____ Date: _____

For Administrative Use Only:

Date: _____

Effective Enrollment Period Dates: _____

Approved By: _____

Premium Amount: _____

For more information

Call 1-800-505-4160 or Email customerservice@uhcsr.com

United Healthcare

Processor Date Stamp Received

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

RHODES COLLEGE 2024-1262-62

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ 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: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ 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: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Student's Signature: ____ Date: ______________

Campus/School Attending: _Rhodes College_____

☐ I elect to purchase Injury and Sickness insurance coverage under the College's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Graduate

ID Codes		Monthly (MX)
1	Student	☐ $ 268.67
2	Spouse	☐ $ 266.50
3	One Child	☐ $ 266.50
4	Two or more Children	☐ $ 533.00
5	Spouse + two or more Children	☐ $ 799.50

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Undergraduate

ID Codes		Monthly (MX)
6	Student	☐ $ 194.09
7	Spouse	☐ $ 191.92
8	One Child	☐ $ 191.92
9	Two or more Children	☐ $ 383.84
10	Spouse + two or more Children	☐ $ 575.76

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

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: $268.67 x 3 months = $806.01

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 is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.