UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK ENROLLMENT FORM FOR DEPENDENTS

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STATE UNIVERSITY OF NEW YORK

2022-203419-41

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.				
LAST (FAMILY) NAME:	FIRST (GIVEN) NA	AME:		MIDDLE INITIAL:
GENDER: □ MALE □ FEMALE □ U	DATE OF BIRTH: (MONTH/DAY/YEAR)		SC	HOOL ID #:
PERMANENT U.S. ADDRESS: (HOUSE/BI	JILDING # AND STREET N.	AME)		
CITY:		STATE:		ZIP CODE:
TELEPHONE #:		EMAIL ADDI	RESS:	•
DEPENDENT INFORMATION Complete information below for dependents include a blank sheet for additional dependents		overage is only	v available for	students insured under the Plan (Please
SPOUSE:	GENDER:	MALE 🗆 l	DATE OF (MONTH)	BIRTH: DAY/YEAR)
First (Given) Name:	Middle Initial:		Last (Family)	Name:
CHILD:	GENDER:	MALE 🗆 L	DATE OF (MONTH)	BIRTH: DAY/YEAR)
First (Given) Name:	Middle Initial:		Last (Family)	Name:
CHILD:	GENDER:	MALE 🗆 L	DATE OF (MONTH)	BIRTH: DAY/YEAR)
First (Given) Name:	Middle Initial:		Last (Family)	Name:
CHILD:	GENDER:	MALE 🗆 U	DATE OF (MONTH)	BIRTH: DAY/YEAR)
First (Given) Name:	Middle Initial:		Last (Family)	Name:
CHILD:	GENDER:	MALE 🗆 U	DATE OF (MONTH)	BIRTH: 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 hereto, 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 he stated value of the claim for each such violation				
Student's Signature:				Date:

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Campus/School Attending:						
Plea	Please print name of University. Must be completed in order for application to be processed.					
	I elect to purchase Injury and Shave made.	ickness insurance coverage under the University's student insurance plan. Below are the choices I				
PLE	PLEASE CHECK ALL APPROPRIATE BOXES.					
INSL	RED 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	□ \$ 2,319.00	□ \$ 972.07	□ \$ 959.37	
3	One Child	□ \$ 2,319.00	□ \$ 972.07	□ \$ 959.37	
4	Two or more Children	□ \$ 4,638.00	□ \$ 1,944.14	□ \$ 1,918.74	
5	Spouse + two or more Children	□ \$ 6,957.00	□ \$ 2,916.21	□ \$ 2,878.11	
ID (Codes	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
2	Spouse	□ \$ 1,346.93	□ \$ 584.52	□ \$ 193.25	□ \$ 101.65
3	One Child	□ \$ 1,346.93	□ \$ 584.52	□ \$ 193.25	□ \$ 101.65
4	Two or more Children	□ \$ 2,693.86	□ \$ 1,169.04	□ \$ 386.50	□ \$ 203.30
5	Spouse + two or more Children	□ \$ 4,040.79	□ \$ 1,753.56	□ \$ 579.75	□ \$ 304.95

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	\$ 2,316.62	\$ \$ 971.08	\$ 958.38	
One Child	\$ 2,316.62	\$ \$ 971.08	\$ 958.38	
Two or more Children	\$ 4,633.24	\$ \$ 1,942.16	\$ 1,916.76	
Spouse + two or more Children	\$ 6,949.86	\$ \$ 2,913.24	\$ 2,875.14	
	Spring/Summer (J-)	Summer (S-)	Monthly (MX)	16 days (1-)
Spouse	\$ 1,345.54	\$ 583.92	\$ 193.05	\$ 101.55
One Child	\$ 1,345.54	\$ 583.92	\$ 193.05	\$ 101.55
Two or more Children	\$ 2,691.08	\$ 1,167.84	\$ 386.10	\$ 203.10
Spouse + two or more Children	\$ 4,036.62	\$ 1,751.76	\$ 579.15	\$ 304.65

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.

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EFFECTIVE/EXPIRATION	PERIODS:				
Annual	8/15/2022	to	8/14/2023		
Fall	8/15/2022	to	1/14/2023		
Spring	1/15/2023	to	6/14/2023		
Spring/Summer	1/15/2023	to	8/14/2023		
Summer	5/15/2023	to	8/14/2023		
EFFECTIVE AND TERMII Coverage will become effe			he Insurance Company receives the application and correct premium payment.		
Monthly coverage expires 1 month following receipt of your premium or 8/14/2023, 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: \$193.25 x 3 months = \$579.15		
CALCULATION FOR MONTHLY PREMIUM:					
Monthly premium: \$					
Multiply by # of month					
Total premium enclosed: \$					
Payment Instructions: Note that the Payment Instructions is form along with premium payments.		mone	y order payable to UnitedHealthcare Student Resources in US dollars. Mail this enrollment		
UnitedHealthcare Student	tResources				
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.					

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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.

Amhari

Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 2723-260-866-1.

Armenian

Ձեզ մատչելի են անվՃար լեզվական օգնության ծառայություններ։ 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- Bangala

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

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အစမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ် ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។

សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee

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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 hochi 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 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.

Greel

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarat

ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કુપા કરીને 1-866-260-2723 પર ક્રૉલ 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 निःशुल्क 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.

Indonesia

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.

Japanes

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。

Karer

ကျိုာ်တါမၤစၢၤအင်္ဂါနမၤနု၊်အီးသုဝဲလၢတလိဉ်ဟုဉ်အပူးဘဉ်(ဒီလီ)နှဉ်လီး. ဝံသးစူးဆုံးကျိုးဘဉ် 1-866-260-2723တက္၊.

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 yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمەتەكاتى يىلرمەتىيى زمانى بەخۋر ايى بۆ تۆ دابين دەكريّن. تكايە تەلمەقۇن بكە بۆ ژمار «ي 2722-660-866-1.

Laotia

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່ຳໃຫ້ແກ່ທ່ຳນ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi

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

Marshallese

Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjelok wōṇāān. Jouj im kallok 1-866-260-2723.

Micronesian-Pohnpeian

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

Navajo

Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shoodí kohji' 1-866-260-2723 hodíilnih.

Nepali

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

Nilotic-Dinka

Käk ë kuny ajuser ë thok atö tinë yin abac të cin wëu yeke thiëëc. Yin cəl 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 2723-260-1866 تماس بگیرید.

Polish

Możesz skorzystać z bezplatnej 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 maaɗa. 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

چەچەقتە تەخنۇقە تەلقىمە ئېچىدىنىڭ بىلىدىنىڭ تارىخى ئايىنىڭ ئەركىدە ئەركىدە ئايىدە ئايىدىنىڭ ئايىدىنىڭ ئايىدىن ئايىرى ئىلىرى ئايىدىنىڭ 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.

Telugi

లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่า ยแต่อย่างใด 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 بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 2723-266-1 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 אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba

Isé ìrànlówó èdè tí ó jé òfé, wà fún ó. Pe 1-866-260-2723.