

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR ATHENS AND REGIONAL CAMPUS STUDENTS
AND THEIR DEPENDENTS

OHIO UNIVERSITY

2023-1103-2

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.			
SOCIAL SECURITY #:		STUDENT PID #	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	EXPECTED DATE OF GRADUATION: (MONTH/YEAR)	
LOCAL U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		OHIO UNIVERSITY 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 SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:		Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:		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) He/She has carefully read the Certificate of Coverage and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

DOMESTIC STUDENTS

Choose your Campus Location:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Athens | <input type="checkbox"/> Eastern (St. Clairsville) | <input type="checkbox"/> Proctorville |
| <input type="checkbox"/> Chillicothe | <input type="checkbox"/> eCampus | <input type="checkbox"/> Southern (Ironton) |
| <input type="checkbox"/> Cleveland | <input type="checkbox"/> Lancaster | <input type="checkbox"/> Zanesville |
| <input type="checkbox"/> Dublin | <input type="checkbox"/> Pickerington | |

INSURED CATEGORY:

- Domestic Undergraduate Domestic Medical (HCOM)
 Domestic Graduate

ID Codes

- | | Fall (F-) | Spring 1 (G1) | Summer (S-) |
|------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| 1 Student | <input type="checkbox"/> \$ 1,138.00 | <input type="checkbox"/> \$ 1,121.00 | <input type="checkbox"/> \$ 839.00 |
| 2 Spouse | <input type="checkbox"/> \$ 1,138.00 | <input type="checkbox"/> \$ 1,121.00 | <input type="checkbox"/> \$ 839.00 |
| 3 One Child | <input type="checkbox"/> \$ 1,138.00 | <input type="checkbox"/> \$ 1,121.00 | <input type="checkbox"/> \$ 839.00 |
| 4 Two or more Children | <input type="checkbox"/> \$ 2,276.00 | <input type="checkbox"/> \$ 2,242.00 | <input type="checkbox"/> \$ 1,678.00 |

EFFECTIVE/EXPIRATION PERIOD

- Fall 8/20/2023 to 12/31/2023
 Spring 1 1/1/2024 to 5/11/2024 Summer 5/12/2024 to 8/19/2024

INTERNATIONAL STUDENTS

Choose your Campus Location:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Athens | <input type="checkbox"/> Eastern (St. Clairsville) | <input type="checkbox"/> Proctorville |
| <input type="checkbox"/> Chillicothe | <input type="checkbox"/> eCampus | <input type="checkbox"/> Southern (Ironton) |
| <input type="checkbox"/> Cleveland | <input type="checkbox"/> Lancaster | <input type="checkbox"/> Zanesville |
| <input type="checkbox"/> Dublin | <input type="checkbox"/> Pickerington | |

INSURED CATEGORY:

- International Undergraduate International Medical (HCOM)
 International Graduate

ID Codes

- | | Fall (F-) | Spring 1 (G1) | Summer (S-) |
|------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| 6 Student | <input type="checkbox"/> \$ 1,138.00 | <input type="checkbox"/> \$ 1,121.00 | <input type="checkbox"/> \$ 839.00 |
| 7 Spouse | <input type="checkbox"/> \$ 1,138.00 | <input type="checkbox"/> \$ 1,121.00 | <input type="checkbox"/> \$ 839.00 |
| 8 One Child | <input type="checkbox"/> \$ 1,138.00 | <input type="checkbox"/> \$ 1,121.00 | <input type="checkbox"/> \$ 839.00 |
| 9 Two or more Children | <input type="checkbox"/> \$ 2,276.00 | <input type="checkbox"/> \$ 2,242.00 | <input type="checkbox"/> \$ 1,678.00 |

EFFECTIVE/EXPIRATION PERIODS:

- Fall 8/20/2023 to 12/31/2023
 Spring 1 1/1/2024 to 5/11/2024 Summer 5/12/2024 to 8/19/2024

Submit this form via email to:
Ohio University, Student Health Insurance Administrator
at studentinsurance@ohio.edu

To locate this enrollment form online please visit www.uhcsr.com/ohio.



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.

Marathi

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

Marshallese

Kwomaroñ bōk jermal 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 áka'e'eyeed bee áka'nída'wo'ígíí t'áá jiik'eh bee nich'i' bee ná'ahoot'i'. T'áá shqódi 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 ajueer ē thok atō tinē yin abac tē cin wēu yeke thiēēc. Yin 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

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

1-866-260-2723

Thai

1-866-260-2733

Tongan- Fakatonga

1-866-260-2723

Trukese (Chuukese)

1-866-260-2723

Turkish

1-866-260-2723 numarayı arayınız.

Ukrainian

1-866-260-2723

Urdu

1-866-260-2723 پر کال کریں۔

Vietnamese

1-866-260-2723

Yiddish

1-866-260-2723

Yoruba

1-866-260-2723