UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

rocessor Date Stamp Received Here	

CLARKSON UNIVERSITY

2023-781-61

	OL/ II (I COOI V OI	VIV EIXOII I		2020 701 01
PRIMARY INSURED COMPLETE INFOR	MATION BELOW FOR ST	JDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) N	AME:		MIDDLE INITIAL:
GENDER:	DATE OF BIRTH:		SCHO	 OOL ID #:
□ MALE □ FEMALE □ U	(MONTH/DAY/YEAR)			
PERMANENT U.S. ADDRESS: (HOUSE/BU	ILDING # AND STREET N	AME)	1	
CITY:		STATE:		ZIP CODE:
TELEPHONE #:		EMAIL ADD	DRESS:	
DEPENDENT INFORMATION				
Complete information below for dependent Plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for an arrival plan (Please include a blank sheet for		ident covera	ige is only availat	ole for students insured under the
SPOUSE:	GENDER:		DATE OF BI	RTH:
	□ MALE □ FE	MALE	U (MONTH/DA	Y/YEAR)
First (Given) Name:	Middle Initial:		Last (Family) Na	ame:
CHILD:	GENDER:	MALE 🗆	U (MONTH/DA	
First (Given) Name:	Middle Initial:		Last (Family) No	ame:
CHILD:	GENDER:		DATE OF BI	RTH:
		MALE	U (MONTH/DA	
First (Given) Name:	Middle Initial:		Last (Family) Na	ame:
CHILD:	GENDER:		DATE OF BI	
First (O' as a) No as a		MALE	U (MONTH/DA	<u> </u>
First (Given) Name:	Middle Initial:		Last (Family) Na	
CHILD:	GENDER:		DATE OF BI	
		MALE	U (MONTH/DA	
First (Given) Name:	Middle Initial:		Last (Family) Na	ame:J
NOTICE TO STUDENT: Coverage will be of the Company or the effective date of the signing, the student acknowledges the follows indicated on this enrollment form; 2) Rathe eligibility requirements for this coverage student is not eligible, the premium will be reorces. NOTICE: Any person who knowingly an	e coverage period, which owing: 1) The student has tes are not pro-rated othe le as described in the C efunded. Premium will no	never is later, is carefully re er than as lis ertificate of (ot be refunde	, unless otherwised the Certificate sted on this enroll Coverage; and 4 ed except for inelia	te stated in the Master Policy. By the of Coverage and elects to enroll iment form; 3) The student meets of the little in the later determined that the gibility or entrance into the armed
insurance or statement of claim containformation concerning any fact material to a civil penalty not to exceed five thou Student's Signature:	thereto, commits a frauc	dulent insurai	nce act, which is	a crime, and shall also be subject
				Date:

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С	ampus Location:			
	CLARKSON UNIVERS	511 Y		
	I elect to purchase Injurchoices I have made.	ry and Sickness insura	ance coverage under the	College's student insurance plan. Below are the
PI	LEASE CHECK ALL APPROF	PRIATE BOXES.		
١N	ISURED CATEGORY:	☐ Athletes		□ Undergraduate
		☐ Internation	nal	· ·
	TAL PLAN COST: The To breakdown of the insurance			mium and additional fees. See the table below for Plan Cost.
D (Codes	Annual (A-)	Spring/Summer (J-)	Summer (S-)
2	Spouse	□ \$ 2,569.00	□ \$ 1,494.85	□ \$ 645.73
3	One Child	□ \$ 2,569.00	□ \$ 1,494.85	□ \$ 645.73
4	Two or more Children	□ \$ 5,138.00	□ \$ 2,989.69	□ \$ 1,291.46
5	Spouse + two or more Children	□ \$ 7,707.00	□ \$ 4,484.55	□ \$ 1,937.19

INSURANCE PLAN PREMIUM: The premium below is for the insurance coverage underwritten by UnitedHealthcare Insurance Company o 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 a to equal the Total Plan Cost. Please remit the Total Plan Cost from the table above.

	Annual (A-)	Spring/Summer (J-)	Summer (S-)
Spouse	\$ 2,495.62	\$ 1,452.36	\$ 627.31
One Child	\$ 2,495.62	\$ 1,452.36	\$ 627.31
Two or more Children	\$ 4,991.24	\$ 2,904.72	\$ 1,254.62
Spouse + two or more Children	\$ 7,486.86	\$ 4,357.08	\$ 1,881.93

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.
- Annual **Administrative fee of \$50.00 charged by the school you are receiving coverage through which may, for example, cover
 your school's administrative costs associated with offering this health plan.
- Annual **Service fee of \$21.00 charged by or at the direction of the school you are receiving coverage through to cover the costs
 of services provided by a non-insurer vendor or consultant.

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/1/2023	to	7/31/2024
☐ Spring/Summer	1/1/2024	to	7/31/2024
☐ Summer	5/14/2024	to	7/31/2024

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Payment Instructions: Make check or money order payable to name of authorized representative 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.
The State of New York requires UnitedHealthcare Insurance Company of New York to request the following information about the Donate Life Registry. You must fill out the following section.
Would you like to be added to the Donate Life Registry?

Yes □

Skip this question $\hfill\Box$

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Check box for 'yes' or 'skip this question'.

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.

Amharie

የቋንቋ አርዳታ አንልግሎዮች በነጻ ይንኛሉ። አባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 2723-260-66-1.

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 বিনামূল্যে পেতে পারেন। দ্যা করে 1-866-260-2723 –তে কল করুন।

Burmese

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

Cambodian- Mon-Khmer

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

Cherokee

\$የጋኬብፙቭ ውፀኒፙ\$ጓቭ ውፀኒማET ኬብ RGኖውፐፙኒብጓT ከኒEGGኖθ D4(∂T. IG(∂ Dh ØbWኖቴ 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。

Choctav

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.

Greek

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

Guiarati

ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા 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.

The

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。

Kare

ကျိာ်တာ်မေစၤအင်္ဂါနမေန့ ဂ်ဴအီးသုဝဲလာတလိဉ်ဟ္ဉာ်အပူးဘဉ်(ဒီလီ)နှဉ်လီး. ဝံသးရူးဆုံးကျိုးဘဉ် 1-866-260-2723တက္ကုံ.

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 يارمەتيى زمانى بەخۇر ايى بۇ تۇ دابين دەكرين. تكايە تەلەفۇن بكە بۇ ر مار دى 272-600-66-1.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄໍ່າໃຫ້ແກໍ່ທໍ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi

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

Marshallese

Kwomaroñ bök jerbal in jipañ in kajin ilo ejjelok wönään. 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'ígíi t'áá jíík'eh bee nich'j' bee ná'ahoot'i'. T'áá shoodí kohjj' 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 atō tīnē yīn abac të cīn wëu yeke thieëc. Yīn col 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 زياتي به طور رايگان در اختيار شما مي باشد. لطفاً با شماره 2723-662-1861 تماس بگيريد.

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.

Punjab

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 le 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

چەرەقىقە» دەنبۇقە» داغى»، «چەرەبىلە، ئەبىلە ھۆپە» ئاللەمەن . ماشەنەمەن مەنى خارەمىتە» 1-866-260-2723

Tagalo

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 pë 'a e sëvesi 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 میربانی 2723-260-1866 پر کال کریں۔

Vietnamese

Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddisl

שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba

Isé iranlówó ede tí ó jé ôfe, wà fún ó. Pe 1-866-260-2723.