The University of Alabama at Birmingham
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 (8/15/20 – 8/14/21), you can enroll in The University of Alabama at Birmingham 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:**

Name: ____________________________ (Last name, first name)

School ID #: ____________________________ (Required)

**ENROLLMENT & PAYMENT INSTRUCTIONS:**

A QLE is required for the primary insured 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.

Make check or money order payable to UnitedHealthcare StudentResources in US dollars. Mail this completed form, your school injury and sickness insurance enrollment form, required supporting documentation, along with premium payment to: UnitedHealthcare StudentResources; 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 SIDPremiumDataEntry@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:** 1-800-767-0700 or Email customerservice@uhcsr.com

**FOR ADMINISTRATIVE USE ONLY:**

Date: _______________ Approved By: ________________________________

Effective Enrollment Date: _______________ Premium Amount: ________________________________