Processor Date Stamp Received Here

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS ONLY

RANDOLPH – MACON COLLEGE 2022-1420-65

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE ☐ U	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 ☐ U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE ☐ U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE ☐ U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE ☐ U	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD:	GENDER: ☐ MALE ☐ FEMALE ☐ U	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: Any person who, with the 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 may have violated state law.

Student's Signature: ____ Date: ______________

Campus Location:

☐ Randolph-Macon College

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

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Domestic Undergraduate ☐ International

ID Codes		Annual (A-)	Spring/Summer (J-)
2	Spouse	☐ $ 2,630.00	☐ $ 1,308.00
3	One Child	☐ $ 2,630.00	☐ $ 1,308.00
4	Two or more Children	☐ $ 5,260.00	☐ $ 2,616.00
5	Spouse + two or more Children	☐ $ 7,890.00	☐ $ 3,924.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 8/1/2022 to 7/31/2023

☐ Spring/Summer 2/1/2023 to 7/31/2023

Payment Instructions: Make check or money order payable to First Risk Advisors in US dollars. Mail this enrollment form along with premium payment to:

First Risk Advisors
67 W Court Street
Doylestown, PA 18901

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.

The Virginia Health Information Organization requests the following information about the Primary Insured. If you choose not to provide this information, please select the appropriate box below.

☐ I have read the request for information and choose not to supply a response.

Primary Race (select one)		
☐	R1	American Indian / Alaska Native
☐	R2	Asian
☐	R3	Black / African American
☐	R4	Native Hawaiian or other Pacific Islander
☐	R5	White
☐	R9	Other (please enter)
☐	UNKNOWN	Unknown / Not Specified

Secondary Race (select one)		
☐	R1	American Indian / Alaska Native
☐	R2	Asian
☐	R3	Black / African American
☐	R4	Native Hawaiian or other Pacific Islander
☐	R5	White
☐	R9	Other (please enter)
☐	UNKNOWN	Unknown / Not Specified

Are you Hispanic/Latino/Spanish: ☐ Yes ☐ No ☐ Unknown

Primary Ethnicity (select one)		
☐	2060-2	African
☐	2058-6	African American
☐	AMERCN	American
☐	2028-9	Asian
☐	2029-7	Asian Indian
☐	BRAZIL	Brazilian
☐	2033-9	Cambodian
☐	CVERDN	Cape Verdean
☐	CARIBI	Caribbean Island
☐	2155-0	Central American (not otherwise specified)
☐	2034-7	Chinese
☐	2169-1	Columbian
☐	2182-4	Cuban
☐	2184-0	Dominican
☐	EASTEU	Eastern European
☐	2108-9	European
☐	2036-2	Filipino
☐	2157-6	Guatemalan
☐	2071-9	Haitian
☐	2158-4	Honduran

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☐	2036-2	Filipino
☐	2157-6	Guatemalan
☐	2071-9	Haitian
☐	2158-4	Honduran

☐	2039-6	Japanese
☐	2040-4	Korean
☐	2041-2	Laotian
☐	2148-5	Mexican, Mexican American, Chicano
☐	2118-8	Middle Eastern
☐	PORTUG	Portuguese
☐	2180-8	Puerto Rican
☐	RUSSIA	Russian
☐	2161-8	Salvadoran

☐	2039-6	Japanese
☐	2040-4	Korean
☐	2041-2	Laotian
☐	2148-5	Mexican, Mexican American, Chicano
☐	2118-8	Middle Eastern
☐	PORTUG	Portuguese
☐	2180-8	Puerto Rican
☐	RUSSIA	Russian
☐	2161-8	Salvadoran

Primary Ethnicity (select one)		
☐	2165-9	South American (not otherwise specified)
☐	2047-9	Vietnamese
☐	OTHER	Other (please specify)
☐	UNKNOWN	Unknown / Not Specified

Secondary Ethnicity (select one)		
☐	2165-9	South American (not otherwise specified)
☐	2047-9	Vietnamese
☐	OTHER	Other (please specify)
☐	UNKNOWN	Unknown / Not Specified

Primary Language (select one)		
☐	799	African Languages (please specify)
☐	777	Arabic
☐	708	Chinese (please specify)
☐	601	Cape Verdean Creole
☐	600	English
☐	620	French
☐	607	German
☐	637	Greek
☐	623	Haitian Creole
☐	778	Hebrew
☐	663	Hindi
☐	619	Italian
☐	723	Japanese
☐	724	Korean
☐	656	Persian
☐	645	Polish
☐	629	Portuguese
☐	639	Russian
☐	625	Spanish
☐	742	Tagalog
☐	671	Urdu
☐	728	Vietnamese
☐	997	Other (please specify)
☐	998	Declined
☐	999	Unavailable

NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources 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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call 1-866-260-2723.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-866-260-2723.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-866-260-2723.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-260-2723.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：**日本語 (Japanese)** を話される場合、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 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-260-2723 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-260-2723។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-260-2723 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.