# UnitedHealthcare Student Resources
# Insurance Enrollment 2024-2025

University of Rhode Island Injury and Sickness Insurance Plan for Spouses, Dependents and Full/Part-time Students (Please print all information)

Student Last Name: _____ First Name: _____ Middle Initial: ____

U.S. Home Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

School ID #: _____ DOB: _____ Gender: _____

I have read the description of the Student Injury and Sickness Insurance Plan offered to students attending the University of Rhode Island and their eligible dependents, and wish to enroll as follows:

Please check one: Undergrad ☐ Grad ☐

**ANNUAL ENROLLMENT**

| Check Applicable Box(es): | DOMESTIC 9/1/24–8/31/25 | INTERNATIONAL 9/1/24–8/31/25 |
|---|---|---|
| Student: | ☐ $3,291 | ☐ $3,291 |
| Spouse: | ☐ $3,291 | ☐ $3,291 |
| Child: | ☐ $3,291 | ☐ $3,291 |
| Two or more Children: | ☐ $6,567 | ☐ $6,567 |

Please identify the dependents on this form:

| Dependent's Name (Last, First) | Relationship | Date of Birth | Gender | Phone | Email |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Please check one: Undergrad ☐ Grad ☐

**2nd SEMESTER ENROLLMENT**

| Check Applicable Box(es): | DOMESTIC 1/1/25–8/31/25 | INTERNATIONAL 1/1/25–8/31/25 |
|---|---|---|
| Student: | ☐ $2,196 | ☐ $2,196 |
| Spouse: | ☐ $2,196 | ☐ $2,196 |
| Child: | ☐ $2,196 | ☐ $2,196 |
| Two or more Children: | ☐ $4,377 | ☐ $4,377 |

Please identify the dependents on this form:

| Dependent's Name (Last, First) | Relationship | Date of Birth | Gender | Phone | Email |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

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.

I want to purchase the University of Rhode Island Student Injury and Sickness Insurance Plan. I understand that my student account will be billed for the selected coverage. I also understand that I will be billed the Health Services Fee ($323/semester) for both myself and my spouse (if applicable). Children are not seen at Health Services and will not be charged the Health Services Fee. I further understand that if I elect to enroll, I must submit this application to the University of Rhode Island Student Health Services at the address listed below.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

**Student Signature:** _____ **Date:** _____

**Mail/Fax/Bring To: University Of Rhode Island Health Services - Insurance, 6 Butterfield Road, Kingston, RI 02881-0813**
**Phone: 401-874-4774 Fax: 401-874-9270 Email: health@uri.edu**

Received at Health Services by: _____ Date: _____ Via: _____

Confirmed Matriculating Student Date: _____ Initials: _____

Charge Already on Student's Tuition Bill Date: _____ Initials: _____

Posted to Student's Tuition Bill Date: _____ Initials: _____

Uploaded to FTP/List or PC Add Date: _____ Initials: _____

Emailed Student Date: _____ Initials: _____