UnitedHealthcare Student Resources Insurance Enrollment 2026-2027

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 9/1/26–8/31/27	INTERNATIONAL 9/1/26–8/31/27
Student:	☐ $3,512	☐ $3,512
Spouse:	☐ $3,512	☐ $3,512
Child:	☐ $3,512	☐ $3,512
Two or more Children:	☐ $7,009	☐ $7,009

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 1/1/27–8/31/27	INTERNATIONAL 1/1/27–8/31/27
Student:	☐ $2,343	☐ $2,343
Spouse:	☐ $2,343	☐ $2,343
Child:	☐ $2,343	☐ $2,343
Two or more Children:	☐ $4,671	☐ $4,671

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: _____