2023-2024 Cancellation Request Form
Graduate Medical Education Residents and Fellows

Cancellation request form for residents and fellows in job codes 9556, 9559, 9582, 9583, 9555, 9554, 9568 and 9569. To cancel coverage, please complete and return this form to the Office of Student Health Benefits. Please keep a copy for your records. If you are requesting to cancel coverage outside of open enrollment, you must provide a Certificate of coverage from your new insurance provider within 30 days of the start date of the new coverage.

A. Resident/Fellow Information

Name (last, first, middle initial) *(please print)* | Date of birth (mm/dd/yyyy) | U of M ID number

Street address, city, state, ZIP code | Daytime phone | Email address

B. Cancellation Information

- ☐ Cancel medical plan – you are also required to submit the Health Insurance Waiver Request form and a certificate of coverage from your new insurance provider
- ☐ Cancel dental plan
- ☐ Cancel life insurance

To cancel COBRA coverage, please contact BRI directly at 866-996-5200, Extension 1 or participantservices@benefitresource.com.

C. Please name all persons whose coverage you would like to cancel

- ☐ Resident/Fellow
  - ☐ Spouse _____
    Name (last, first, middle initial) *(please print)* | Date of birth
  - ☐ Child _____
    Name (last, first, middle initial) *(please print)* | Date of birth
  - ☐ Child _____
    Name (last, first, middle initial) *(please print)* | Date of birth

If more than two children, please use the back of this form.

D. Resident/Fellow Acknowledgement

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the University of Minnesota, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of us the use of my U of M ID number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by us on this application may invalidate my and/or my dependent's coverage.

Resident/Fellow signature (electronic signatures are not accepted) | Date signed

Please submit to: Office of Student Health Benefits, 410 Church Street SE, N323, Minneapolis, MN 55455
Email: umshbo@umn.edu Phone: 612-624-0627 Fax: 612-626-5183 or 1-800-624-9881 Website: shb.umn.edu