2023-2024 Graduate Assistant Health Plan
Continuation of Coverage Enrollment and Change Form

After losing eligibility for the Graduate Assistant Health Plan (for example, your assistantship drops below 25%, you leave your appointment, or your appointment, fellowship, or traineeship ends), plan members have the option to continue coverage for up to 18 months at their own expense. To request continuation, **please complete and mail or bring this form directly to the address listed at the bottom of this form** for the Office of Student Health Benefits within 60 days of loss of coverage.

For more information on this option, contact the Office of Student Health Benefits. Please keep a copy of this form for your records.

A. Graduate Assistant Information

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

Street address, city, state, ZIP code | Daytime phone | U of M email address

I would like to (please select all that apply):

- ☐ Continue my coverage - $666.56
- ☐ Continue my dependent coverage – choose plan below
- ☐ Cancel my coverage and all dependent coverage (eligible cancellations will occur at the end of the month in which form is received)
- ☐ Cancel coverage for the dependents listed below, but keep my own coverage (eligible cancellations will occur at the end of the month in which form is received)
- ☐ Other, please specify_____

B. Dependent Enrollment Information – Choose plan and name dependents to be covered (all dependents must be on same plan as previously enrolled)

	Plan 1	Member Payment*		Plan 2	Member Payment*
☐	Spouse	$513.12/month	☐	Spouse	$800.31/month
☐	Child	$521.37/month	☐	Child	$808.56/month
☐	Children	$731.11 /month	☐	Children	$945.65/month
☐	Family**	$1,188.48/month	☐	Family**	$1,539.78/month

*Total cost will be cost of selected dependent plan PLUS cost of graduate assistant's coverage.

**Family coverage is defined as spouse and one or more child.

☐ Graduate assistant – All Graduate Assistants in the Graduate Assistant Health Plan are enrolled in Plan 1. Graduate Assistants can choose to enroll dependents in either Plan 1 or Plan 2, but all dependents must be in the same plan. Dependents cannot change plan mid-year. Please see back of this form for details.

☐ Spouse _____
Name (last, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

If more than three dependents, please use another sheet.

C. Graduate Assistant Signature

Graduate assistant signature (electronic signatures are not accepted) | Date signed

Please submit to: Office of Student Health Benefits, 410 Church Street SE, N323, Minneapolis, MN 55455

Phone: 612-624-0627 Website: shb.umn.edu

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D. Determine Your Total Amount Due with Enrollment Form

Please enter costs from the reverse side on the form below. You must enclose method of payment for the first two months of coverage with this enrollment form. You may select the option to pay subsequent payments by credit or debit card automatically, or receive monthly payment coupons. Payment is due no later than the 20th of the month preceding the coverage month (for example, payment is due no later than October 20 for November coverage). Failure to remit payments by the payment due date will result in interruption or loss of coverage.

$ 666.56 GA coverage – $0.00 due at enrollment, charge for GA coverage will occur at the start of the semester

\+ $_____ Dependent coverage, monthly member payment – from reverse side (if no dependents, add $0.00)

x 2 First two months payment due with enrollment form

= $_____ Total amount due with enrollment form

E. Select Payment Method - Our office cannot accept forms with credit card information by email. Please mail or bring directly to the address listed at the bottom of the form.

- ☐ My check (payable to the University of Minnesota) for the total amount due is enclosed or I am paying cash in person. Please charge my credit or debit card for my total monthly premium between the 15th and 20th of each month until I cancel coverage or provide written notification to discontinue charge authorization (automatic billing).
- ☐ Charge the total amount due to my credit or debit card. Charge my credit or debit card for my total monthly premium between the 15th and 20th of each month until I cancel coverage or provide written notification to discontinue the charge authorization (automatic billing).
- ☐ My check (payable to the University of Minnesota) for the total amount due is enclosed or I am paying cash in person. Please send me monthly payment coupons for subsequent check or cash premium payments.
- ☐ Charge the total amount due to my credit or debit card. Send me monthly payment coupons for subsequent premium payments to be made by check or cash.

F. Card Information (if applicable)

Name of graduate assistant, trainee, or fellow _____ U of M ID number _____

Credit/debit card (select one): ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on card _____ Card number _____ Expiration date _____

Authorizing signature (electronic signatures are not accepted) _____ Date signed _____

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