

2023-2024 Graduate Assistant Health Plan Department Authorization Form

Fellows and trainees are eligible to enroll in the Graduate Assistant Health Plan if their appointing department provides an account string (EFS number) to which the cost of the plan may be charged.

Fellow and trainee eligibility for the Graduate Assistant Health Plan requires:

- A completed Department Authorization Form (this form)
- a completed enrollment form (for new enrollees)

To complete the enrollment process, documents must be submitted to the Office of Student Health Benefits by September 23, 2023, or within 30 days of their appointment start date, whichever is later.

A. Fellow or Trainee Information

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

Graduate program _____

Job class _____

B. Payment Information – this section must be completed for form to be processed

The appointing department will incur a charge of \$7,979.64 for the entire year or \$664.97 per month. The \$664.97 per month breaks down as follows: \$651.55 (plan cost per fellow/trainee), plus \$46.00 (surcharge for department's portion of the University's subsidy of dependent coverage), minus \$32.58 (fellow/trainee's contribution to premium). Post-doctoral fellows must submit payment for their portion of the cost of coverage (\$195.47 per semester or \$390.93 per year).

Account string (EFS number)* to be charged _____

Eight-digit Project Code (only applies to project with a sponsored activity) _____

*Please ensure EFS account string is active for 2023-2024 fiscal year

Fall

Total amount: \$3,324.85
Coverage dates: 9/1/2023 – 1/31/2024

Spring

Total amount: \$2,659.88
Coverage dates: 2/1/2024 – 5/31/2024

Summer

Total amount: \$1,994.91
Coverage dates: 6/1/2024 – 8/31/2024

Dependent(s) – please specify the coverage period and amount

Continuation of Coverage, total amount: \$666.56/month

Specify how many months to fund: _____

Other

C. Department Contact

ACKNOWLEDGEMENT: I understand that by not providing summer EFS authorization in the above section, the listed fellow or trainee will be automatically billed for coverage for the months of June, July, and August unless they complete and submit a Cancellation Form to the Office of Student Health Benefits by May 31, 2024.

Name (last, first, middle initial) *(please print)* _____

Campus address _____

Daytime phone _____

Email address _____

Department contact 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

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