2023-2024 Student Health Benefit Plan
International Scholar Payment Form

A. Scholar Information – please make a plan selection

☐	Primary member	$320/month
☐	Spouse	$403/month
☐	One child	$312/month
☐	Two or more children	$473/month
☐	Family	$1,196/month

B. Determine Total Amount Due

$_____ International scholar coverage

\+ $_____ Dependent coverage (if no dependents, add $0)

X _____2_____ First two months payment due with initial enrollment

= $_____ **Total amount due**

C. Select Payment Method

☐ 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 on the 10th or 25th 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. Please charge my credit or debit card for my total monthly premium on the 10th or 25th 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. I am aware that I must submit payment for the next month of coverage before the expiration date listed on my enrollment form.

☐ Charge the total amount due to my credit or debit card. I am aware that I must submit payment for the next month of coverage before the expiration date listed on my enrollment form.

D. Card Information (if applicable) - **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**

Name of international scholar _____ U of M ID number _____

Credit/debit card – choose one

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on card _____ Card number _____ Expiration date _____

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

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Total cost _____ Effective date of change _____ Term date _____ Processed by _____ Date processed _____ DS 2019/Eligibility term date _____

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

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

Please keep a copy of this form for your records. ©2023 by the University of Minnesota, Office of Student Health Benefits