2024-2025 Health Insurance Waiver Request Form
School of Dentistry Residents and Fellows

University of Minnesota residents and fellows in job codes 9552 and 9553 are required to have health insurance. If you do not want to enroll in the Residents, Fellows and Interns health plan, you must complete this waiver form and prove that you have other health insurance as outlined in section B.

Please complete and return this form to the Office of Student Health Benefits by **June 15, 2024, or within 30 days of your start date, whichever is later**. Please keep a copy of this form for your records.

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. Alternative Health Insurance Information – additional documentation required

Contact your health insurance provider and request a certificate of coverage. Submit your Certificate of Coverage to the Office of Student Health Benefits along with this health insurance waiver request form. The Office of Student Health Benefits cannot accept insurance cards as verification.

☐ I understand I must submit a Certificate of Coverage from my health insurance provider to the Office of Student Health Benefits to be considered for waiver.

C. Acknowledgement (please initial)

_____ I acknowledge that if approved, this waiver will be valid for two years.

_____ I acknowledge that the health insurance I am using to waive the University of Minnesota's Residents, Fellows and Interns health plan may not meet the recommended levels of benefit coverage that the Office of Student Health Benefits and the University of Minnesota advise residents and fellows to carry.

_____ I acknowledge that by requesting this waiver from enrollment in the Residents, Fellows and Interns health plan I will not be eligible to request enrollment in the plan for the duration of the waiver except during the open enrollment period or within 30 days of experiencing a qualifying event as outlined in the plan contract.

D. Resident/Fellow Acknowledgement

ACKNOWLEDGEMENT: I acknowledge that if approved, this waiver will be valid for two years. I understand that if I experience an involuntary loss of coverage during that period, I must enroll in the University of Minnesota's Residents, Fellows and Interns health plan within 30 days of my last date of coverage or wait to enroll at the next open enrollment period.

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
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