2024-2025 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 26, 2024, 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 $8,362.92 for the entire year or $696.91 per month. The $696.91 per month breaks down as follows: $691.87 (plan cost per fellow/trainee), plus $39.63 (surcharge for department's portion of the University's subsidy of dependent coverage), minus $34.59 (fellow/trainee's contribution to premium). Post-doctoral fellows must submit payment for their portion of the cost of coverage ($207.56 per semester or $415.12 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: $3,484.55
Coverage dates: 9/1/2024 – 1/31/2025

☐ Spring
Total amount: $2,787.64
Coverage dates: 2/1/2025 – 5/31/2025

☐ Summer
Total amount: $2,090.73
Coverage dates: 6/1/2025 – 8/31/2025

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

_____

☐ Continuation of Coverage, total amount: $707.41/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, 2025.

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