2024-2025 Graduate Assistant Health Plan Enrollment and Change Form

To enroll in the Graduate Assistant Health Plan, please complete and return this form to the Office of Student Health Benefits by September 26, 2024, or within 30 days of your appointment start date, whichever is later. Coverage for those who miss the deadline will begin on the date this form is received by 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) | Sex | 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):

- ☐ Enroll in the Graduate Assistant Health Plan. I understand that my portion of the cost will be calculated according to my appointment and I am aware of my summer coverage options.
- ☐ Enroll dependents in the Graduate Assistant Health Plan due to:
  - ☐ Open enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other, please specify_____
- ☐ 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). Total cost will be cost of selected dependent plan PLUS cost of graduate assistant's coverage.

Plan 1
- ☐ Spouse, $139.07/month
- ☐ Child, $141.17/month
- ☐ Children, $196.09/month
- ☐ Family (spouse and 1 or more child), $319.70/month

Plan 2
- ☐ Spouse, $216.68/month
- ☐ Child, $218.78/month
- ☐ Children, $256.10/month
- ☐ Family (spouse and 1 or more child), $416.66/month

☐ 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 | Sex

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Sex

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Sex

If more than three dependents, please use another sheet.

C. Acknowledgement

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("us"), I authorize any health care professional or entity to give the health plan administrator or the University of Minnesota, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of us the use of my U of M ID number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by us on this application may invalidate my and/or my dependent's coverage.

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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	Cost (premium)
Rochester and Twin Cities campus graduate assistants (not fellows, trainees, or post-doctoral fellows)	Your account will be charged the base premium, $207.56, at the beginning of each semester. If you have a 50% or less appointment, please see our website, **www.shb.umn.edu/graduate-assistants/gahp-costs**, for additional costs.
Duluth campus graduate assistants (not fellows, trainees, or post-doctoral fellows)	Your account will be charged the base premium, $207.56 at the beginning of each semester.
All campuses graduate fellows, trainees, and post-doctoral fellows (not graduate assistants)	Your account will be charged the base premium, $207.56 at the beginning of each semester. If you do not have an account, you will be required to pay by cash, check, debit or credit card. You must receive a stipend during the academic year equivalent to at least a 25%, nine-month graduate assistantship and your department(s) must agree to pay the full departmental cost of coverage during the academic year.

Summer coverage: If you are enrolled for the entire spring semester, you will remain enrolled for summer unless you submit a Cancellation Form by May 31.

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.

$ 0.00 Graduate Assistant coverage – $0.00 due at enrollment, charge for Graduate Assistant 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
+ $_____ Post-doctoral fellows and trainees only – add $207.56 (base premium), add $0.00 if you are not a post-doctoral fellow or trainee
= **$_____ 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.

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 _____

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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