2024-2025 Student Health Benefit Plan
Enrollment and Change Form

A. Primary Member 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

Campus (check one): ☐ Crookston ☐ Duluth ☐ Morris ☐ Rochester ☐ Twin Cities

What would you like to do? ☐ Enroll myself ☐ Enroll dependent(s) ☐ Other (please describe)_____

Please check all circumstances that apply:

☐ Birth/adoption ☐ Marriage ☐ Other coverage termination

☐ Cancel coverage for dependent(s) listed

☐ Make a change (name/address changes must be made with the University before they can be changed in OSHB records)

B. Enrollment Information – please make plan selection and name all persons to be covered or changed

☐ Primary member, $1,795/semester ☐ One child, **add** $1,870/semester

☐ Spouse, **add** $2,416/semester ☐ Two or more children, **add** $2,838/semester

If eligible, dependents will remain enrolled for the academic year.

☐ 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 the back of this form.

C. Payment Information – primary member premium will be billed to student account

Please choose payment method for dependents, if applicable. Please mail or bring directly to the address at the bottom if providing credit/debit card info.

☐ Bill my student account ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card number (if paying by card) | Expiration date

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

D. Primary Member Authorization

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 Blue Cross and Blue Shield of Minnesota 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 coverage.

Primary member 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