2024-2025 Student Health Benefit Plan
International Student Waiver Request Form

International students are required to enroll in the University-sponsored Student Health Benefit plan unless they are already enrolled in a United States-based employer-sponsored group health plan or the University-sponsored Graduate Assistant Health Plan (GAHP).

To request a waiver from the University-sponsored Student Health Benefit Plan, submit this form to the Office of Student Health Benefits along with proof of coverage or residence in your home country **(Those students that have not traveled to the US on a UMN visa are not required to submit additional documentation).** All eligible students must complete the waiver request process by the posted deadline. Please keep a copy of this form for your records.

A. Student Information

Name (surname, first, middle initial) *(please print)* U of M ID number

Sex Date of birth (mm/dd/yyyy) U of M email address (x500)

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

B. Waiver Selection – what waiver criteria applies to you? Select one.

☐ **A United States-based employer-sponsored or U of M approved government-sponsored group health plan** – Along with this form, please submit proof of coverage, such as a copy of the front and back of your insurance card, letter from your human resources department, a certificate of credible coverage, or scholarship letter.

☐ **University-sponsored Graduate Assistant Health Plan dependent** – Proof of coverage is not required. Please provide primary ID #:_____.

☐ **Graduate Assistant Health Plan Continuation of Coverage** – Proof of coverage is not required. This option is not to be used for students with current appointments that are enrolled/enrolling on the Graduate Assistant Health Plan.

☐ **In residence in my home country** – Along with this form, please submit proof of residence such as a copy of I-94 travel history (preferred for full term waivers), a copy of a flight ticket/itinerary within **3 months** of the last date of arrival into your home country, or a copy of your passport showing stamped entry date into your home country, legal, or lease letter that confirms your current physical location.

C. Acknowledgment

ACKNOWLEDGMENT: I understand that waivers are granted on a semester basis unless otherwise stated and that a waiver request form will need to be submitted every semester by the Twin Cities class registration deadline in order to keep my waiver active.

CONFIDENTIALITY STATEMENT: This communication is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agents responsible for delivering the communication, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify us by telephone and return the communication to us at the below address via the U.S. Postal Service.

Student signature (Signature required, electronic signatures are not accepted) Date signed

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Coverage verified by Date verified Approved by Date approved

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