2024-2025 Student Health Benefit Plan OPT International Student Enrollment and Change Form

Street address									
Street address Apt/Unit/Room # City State ZIP code U of Mr. 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 Recent Arrival Other coverage termination Make a change (name/address changes must be made with the University before they can be changed in OSHB re B. Enrollment Information — please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Child Name (surname, first, middle initial) (please print) Date of birth Sex Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date Date signed D. Primary Member Authorization Authorizing signature (electronic signatures are not accepted) D. Primary Member Authorization Authorizing signature entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all recards or information pertinedical history or services rendered to us for any administrative purpose, including enables of an application or a calim. I also activation to entirity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all recards or informic on behalf of myself and anyone enrolled on or added to this application ("us"), I au health care professional or entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all recards or informic on behalf of myself and anyone enrolled on or added to this application ("us"), I au health care professional or entity to give Blue Cross and Blue Shield of	A. Primary	Member Informat	tion						
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 Recent Arrival Other coverage termination Make a change (name/address changes must be made with the University before they can be changed in OSHB re B. Enrollment Information — please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the C. Payment Information — Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date D. Primary Member Authorization Authorizing signature (electronic signatures are not accepted) 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 au 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 per leaded to use for any administrative purpose, including evaluation or a adjectation or a calient southorize on behalf of the behalf of the provided on the providence or address and the behalf of the providence or address and the behalf of the providence or the providence or address and the behalf of the providence or the providence or address and the behalf of the providence or the providence or address and the behalf of the providence or providence or address and the behalf of the providence or address and t	Name (surname, first, middle initial) (please print)				Date of birth (mm/dd/yyyy)		Sex	U of M ID	number
What would you like to do? Enroll myself Enroll dependent(s) Other (please describe) Please check all circumstances that apply: Birth/adoption Marriage Recent Arrival Other coverage termination Make a change (name/address changes must be made with the University before they can be changed in OSHB re B. Enrollment Information — please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester \$ One child, add \$1,870/semester \$ You or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Date of birth Sex	itreet address		Apt/L	Jnit/Room #	City	State	ZIP code	U of M ema	ail address
Please check all circumstances that apply: Birth/adoption Marriage Recent Arrival Other coverage termination Make a change (name/address changes must be made with the University before they can be changed in OSHB re B. Enrollment Information — please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the C. Payment Information - Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date D. Primary Member Authorization Authorizing signature (electronic signatures are not accepted) D. Primary Member Authorization Authorization to Obtain or relief to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all records or information pehalef of the behalf of the polician in also authorize on behalf of the behalf of the misself and anyone enrolled on or added to this application ("us"), I amediate history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of the behalf of the polician or devaluation of an application or a claim. I also authorize on behalf of the polician or advaluation of an application or a claim. I also authorize on behalf of the polician or advaluation of an application or a claim. I also authorize on behalf of the polician or advaluation of an application or a claim. I also authorize on behalf of the polician or advaluation of an application or a claim. I also authorize on behalf of the polician or advaluation of an application or a claim. I a	Campus (che	eck one): Crool	kston Du	luth	Morris	Rochester	Twin Cities	5	
Recent Arrival Other coverage termination Make a change (name/address changes must be made with the University before they can be changed in OSHB received. B. Enrollment Information – please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) C. Payment Information - Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date Authorizing signature (electronic signatures are not accepted) 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 amelalth care professional or entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any ada all records or information perturbedical history or services rendered to us for any administrative purpose, including evaluation of an application or an application or on resords or information perturbedical history or services rendered to us for any administrative purpose, including evaluation of an application or an application or information perturbedical history or services rendered to us for any administrative purpose, including evaluation of an application or an application or the or professional or entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any ada all records or information perturbed in the purpose, including evaluation of an application or all all records or information perturbed in the purpose including evaluation of an application or an add a	What would	you like to do?	Enroll myself	Enroll o	dependent(s)	Other (please de	escribe)		
Recent Arrival Other coverage termination Make a change (name/address changes must be made with the University before they can be changed in OSHB re B. Enrollment Information – please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Child Name (surname, first, middle initial) (please print) Date of birth Sex Child C. Payment Information - Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date Authorizing signature (electronic signatures are not accepted) 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 au 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 pertinedical history or services rendered to us for any administrative purpose, including evaluation of an application or an application or rendered on behalf of mignesida or the University of Minnesota, any and all records or information pertinedical history or services rendered to us for any administrative non behalf of the application of an application or an application or rendered to us for any administrative purpose, including evaluation of an application or an application or rendered to us for any administrative reprofessional or rendered to us for any administrative reprose.	Please check	k all circumstances th	hat apply:						
Make a change (name/address changes must be made with the University before they can be changed in OSHB responsed in OSHB response response in OSHB responsed in OSHB response response responsed in OSHB response		Birth/adoption	Marria	age					
B. Enrollment Information – please make plan selection and name all persons to be covered Primary member, \$1,795/semester* One child, add \$1,870/semester Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expi Card number Expiration date Authorizing signature (electronic signatures are not accepted) Date signed		Recent Arrival	Other	coverage te	rmination				
Primary member, \$1,795/semester* Spouse, add \$2,416/semester Two or more children, add \$2,838/semester *An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the cash of		Make a change ((name/address char	nges must be	e made with the U	niversity before they	can be changed	l in OSHB recor	ds)
*An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex Child C. Payment Information - Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date D. Primary Member Authorization Authorizing signature (electronic signatures are not accepted) D. Primary Member Authorization Authorization To Obtain OR Release Medical Information ports 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 underlied and anyone enrolled on or added to this application pertimedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of underlied to the authorize on behalf of underlied to the authorize on behalf of underlied to the authorize on behalf of underlied to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of underlied to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of underlied to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of underlied to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of underlied to us for any administrative purpose, including evaluation of an application or a claim.	3. Enrollme	ent Information – ¡	please make pla	n selectio	n and name a	l persons to be co	overed		
An additional \$162.99 Boynton Health fee may apply. Spouse Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the sex of	Prim	mary member, \$1,795/s	semester	One chile	d, add \$1,870/ser	nester			
Spouse Name (surname, first, middle initial) (please print) Date of birth Sex	Spo	use, add \$2,416/semes	ester	Two or n	nore children, ad	\$2,838/semester			
Name (surname, first, middle initial) (please print) Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the sex of the card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Exprint Card number Expiration date Date of birth Sex If more than three dependents, please use the back of the sex of the sex of the card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Exprint Date signed D. Primary Member Authorization Authorizing signature (electronic signatures are not accepted) Date signed D. Primary Member Authorization Authorization To Obtain Obt	*An addition	nal \$162.99 Boynton He	ealth fee may apply	•					
Child Name (surname, first, middle initial) (please print) Date of birth Sex Child Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the more than three dependents, please use the back of the cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expl Card number Expiration date D. Primary Member Authorization Authorizing signature (electronic signatures are not accepted) 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 amelath care professional or entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all records or information pertunedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of university of minnesota, any and all records or information pertunedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of university of minnesota, any and all records or information pertunedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of university of minnesota and plication or a claim.	Spouse								
Name (surname, first, middle initial) (please print) Date of birth Sex Name (surname, first, middle initial) (please print)		Name (surname, first, m	niddle initial) <i>(please p</i>	rint)		Date of b	oirth Se	ex	
C. Payment Information - Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Explantation atteinment of the signed Determined on the signed Determined Determi	Child	Name (surname, first, m	niddle initial) (please p	 rint)		Date of b	Series		
Name (surname, first, middle initial) (please print) Date of birth Sex If more than three dependents, please use the back of the C. Payment Information - Please mail or bring directly to the address at the bottom if providing credit/debit card info. Cash Check Credit/debit card (choose one): Visa MasterCard Discover American 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 au 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 pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of use the bottom if providing evaluation of an application or a claim. I also authorize on behalf of use the bottom if providing providing evaluation of an application or a claim. I also authorize on behalf of use the bottom if providing providing evaluation of an application or a claim. I also authorize on behalf of use the bottom if providing providing evaluation or a claim. I also authorize on behalf of use the bottom if providing evaluation or a claim. I also authorize on behalf of use the bottom if providing evaluation or a claim.		(·····• ,					
Cash Check Credit/debit card (choose one): Visa MasterCard Discover American Expr Card number 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 authealth care professional or entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all records or information pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim. I also authorize on behalf of university of Minnesota or a claim.	Child	Name (surname, first, m	niddle initial) (please p	rint)	If				orm.
Card number 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 au 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 pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of uses the content of the conte	-		ase mail or bring dire	ectly to the a	address at the bot	tom if providing cred	lit/debit card inf	fo.	
Card number 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 authealth care professional or entity to give Blue Cross and Blue Shield of Minnesota or the University of Minnesota, any and all records or information pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of uses the content of the conte		_							
Authorizing signature (electronic signatures are not accepted) Description Description Description AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("us"), I au 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 pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of use of the content of	Cre	dit/debit card (choos	se one): Visa	a	MasterCard	Discover	Am	erican Expres	is
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 au 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 pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of uses the control of the control	Card number					Expiration date			
AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("us"), I au 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 pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of uses the content of	Authorizing sign	nature (electronic signatur	res are not accepted)				Date signed		
AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("us"), I au 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 pertamedical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of uses the content of	D. Primary	Member Authoriza	ation						
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 a incorrect statements knowingly made by us on this application may invalidate coverage.	AUTHORIZATIO nealth care prof nedical history J of M ID Numb	ON TO OBTAIN OR RELEAS fessional or entity to give I or services rendered to us per for the purpose of ider	SE MEDICAL INFORMA Blue Cross and Blue Sh is for any administrativ intification. The informa	ield of Minnes e purpose, inc ation provided	sota or the Universit luding evaluation of I on this application	y of Minnesota, any and an application or a clain	I all records or info n. I also authorize o	ormation pertaini on behalf of us th	ng to ne use of m

Please submit to: Office of Student Health Benefits, 410 Church Street SE, N323, Minneapolis, MN 55455

Phone: 612-624-0627|Website: shb.umn.edu

Date signed

Primary member signature (electronic signatures are not accepted)