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

To enroll in the Student Health Benefit Plan or make changes to your enrollment, please complete and return this form along with all other applicable documents to the Office of Student Health Benefits within 31 days of your arrival date at the University. 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. Please keep a copy of this form for your records.

A. Primary Member Information

Name (surname, first, middle initial) *(please print)* | Date of birth (mm/dd/yyyy) | Sex | U of M ID number

Street address | Apt/Unit/Room # | City | State | ZIP code | U of M email address

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

Program: ☐ Scholar ☐ J-Intern ☐ Other_____

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 ☐ Recent arrival

☐ Cancel coverage for dependent(s) listed ☐ Cancel all coverage

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

☐ Primary member	$320/month	☐ Two or more children	$473/month
☐ Spouse	$403/month	☐ Family	$1,196/month
☐ One child	$312/month		

☐ 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 a second page.

C. 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

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Total cost | Effective date of change | Term date | Processed by | Date processed | DS 2019/Eligibility term date

Please submit to: Office of Student Health Benefits, 410 Church Street SE, N323, Minneapolis, MN 55455
Phone: 612-624-0627 | Website: shb.umn.edu

2024-2025 Student Health Benefit Plan
International Scholar Payment Form

A. Scholar Information – please make a plan selection

☐	Primary member	$320/month
☐	Spouse	$403/month
☐	One child	$312/month
☐	Two or more children	$473/month
☐	Family	$1,196/month

B. Determine Total Amount Due

$_____ International scholar coverage

\+ $_____ Dependent coverage (if no dependents, add $0)

X 2 First two months payment due with initial enrollment

= $_____ **Total amount due**

C. Select Payment Method

☐ 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 on the 10th or 25th 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. Please charge my credit or debit card for my total monthly premium on the 10th or 25th 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. I am aware that I must submit payment for the next month of coverage before the expiration date listed on my enrollment form.

☐ Charge the total amount due to my credit or debit card. I am aware that I must submit payment for the next month of coverage before the expiration date listed on my enrollment form.

D. Card Information (if applicable) - **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**

Name of international scholar _____ U of M ID number _____

Credit/debit card – choose one

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on card _____ Card number _____ Expiration date _____

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

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Total cost _____ Effective date of change _____ Term date _____ Processed by _____ Date processed _____ DS 2019/Eligibility term date _____

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

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