2023-2024 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