# 2025-2026 Student Health Benefit Plan
# International Scholar Waiver Request Form

International scholars are required to enroll in the University-sponsored Student Health Benefit Plan (SHBP) 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 SHBP, submit this form to the Office of Student Health Benefits along with proof of other coverage. All eligible scholars must complete the waiver request process within 31 days of their arrival in the United States. Please keep a copy of this form for your records.

**A. Scholar 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

**B. Health Plan Information – which type of health plan do you have?**

☐ **A United States-based employer-sponsored group health plan** – Scholars who select this option must also submit proof of coverage, such as a copy of the front and back of your insurance card or a certificate of credible coverage obtained from your insurance company.

☐ **University-sponsored Graduate Assistant Health Plan primary or dependent** – Proof of coverage does not need to be submitted by scholars on this plan. Please provide primary's UMN ID: _____.

☐ **Graduate Assistant Health Plan Continuation of Coverage** – Proof of coverage does not need to be submitted by scholars on this plan.

**C. Acknowledgment**

**ACKNOWLEDGMENT:** I understand that waivers are granted based on the health plan information provided along with this waiver request form. If my health plan situation changes, I need to contact the Office of Students Health Benefits within 31 days to notify them of the change.

**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.

Scholar signature (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: 612-435-4230 or 1-800-624-9881 | Website: shb.umn.edu
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