Student Health Benefits
UNIVERSITY OF MINNESOTA
Driven to Discover℠

HealthPartners Benefits
2016–2017 Medical School Residents & Fellows
Enrollment, Change & Payroll Deduction Form

Required enrollment for residents and fellows in job codes 9554, 9555, 9556, 9559, 9568, 9569, 9582, 9583, and optional enrollment for their dependents. If you have other health insurance coverage and do not want to enroll in this HealthPartners plan, you must complete a waiver form. To enroll in or make a change to Residents and Fellows HealthPartners Benefits, please complete and return this form to The Office of Student Health Benefits. All eligible residents and fellows must complete the enrollment process by **June 15, 2016**, or within 14 days of their start date, whichever is later. Please keep a copy of this form for your records.

A. Resident/Fellow Information

Name (last, first, middle initial) *(Please print)* | Date of birth (mm/dd/yyyy) | Gender | U of M ID number | Social Security number

Street address, city, state, ZIP code | Daytime phone | E-mail address

What would you like to do? ☐ Enroll myself (and dependents, if applicable) ☐ Make a change

Open Enrollment/Status Change: After Open Enrollment closes, you can only make changes to your coverage during non-Open Enrollment periods due to a family status change, such as marriage or birth of a child. During Open Enrollment (May 1 to June 15), you can change plans or add or cancel dependent coverage. Within 30 days of a family change, you can add or cancel dependent coverage.

B. Enrollment Information—please make plan selection and name all persons to be covered or cancelled

Basic Option

☐ Resident/Fellow Only	$13.98/pay period
☐ Resident/Fellow and Spouse	$98.64/pay period
☐ Resident/Fellow and Child	$77.32/pay period
☐ Resident/Fellow and Children	$112.30/pay period
☐ Resident/Fellow and Family	$123.82/pay period

Basic Plus Option

☐ Resident/Fellow Only	$34.89/pay period
☐ Resident/Fellow and Spouse	$186.65/pay period
☐ Resident/Fellow and Child	$144.62/pay period
☐ Resident/Fellow and Children	$211.65/pay period
☐ Resident/Fellow and Family	$241.37/pay period

☐ Resident/Fellow

☐ Spouse
Name (last, first, middle initial) *(Please print)* | Date of birth | Gender | Social Security number

☐ Child
Name (last, first, middle initial) *(Please print)* | Date of birth | Gender | Social Security number

☐ Child
Name (last, first, middle initial) *(Please print)* | Date of birth | Gender | Social Security number

If more than two children, please use the back of this form.

C. Resident/Fellow 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 HealthPartners 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 my and/or my dependent's coverage. **AUTHORIZATION TO DEDUCT COST OF PLAN FROM PAYROLL**: I hereby authorize and direct the University of Minnesota to deduct from my stipend checks amounts to cover my tuition, student services fee, and insurance premiums while enrolled as a resident or fellow. Said deductions will be taken from each bi-weekly check. I understand that my department is authorized to make subsequent tuition, student services fee, and insurance premium adjustments at prevailing University of Minnesota rates as appropriate to my resident or fellow classification.

Resident/fellow signature (electronic signatures will not be accepted) | Date signed

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Effective date of change | Department | Approved by | Date approved

Please submit to: Office of Student Health Benefits, 410 Church Street S.E., N323, Minneapolis, MN 55455. Email: umshbo@umn.edu.
Fax: 612-626-5183 or 1-800-624-9881. Please keep a copy of this form for your records. For more information, visit the Office of Student Health Benefits website at www.shb.umn.edu.