

Health Plan Waiver Request

2016–2017 Medical School Residents & Fellows

University of Minnesota residents and fellows in job codes 9554, 9555, 9556, 9559, 9568, 9569, 9582, 9583 are required to have health plan coverage. If you do not want to enroll in the residents and fellows HealthPartners plan, you must complete this waiver form and prove that you have other insurance coverage as outlined in section B.

Please complete and return this form to The Office of Student Health Benefits. All eligible residents and fellows must complete the waiver request 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) <i>(Please print)</i> | 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 |
|---------------------------------------|---------------|----------------|

B. Alternate Health Plan Information—additional documentation required

Contact your health insurance provider and request a certificate of coverage. Submit your certificate of coverage to the Office of Student Health Benefits along with this health plan waiver request form. The Office of Student Health Benefits cannot accept insurance cards as verification of insurance coverage.

I understand I must submit a certificate of coverage from my health insurance provider to the Office of Student Health Benefits to be considered for waiver.

C. Acknowledgment (please initial)

I acknowledge that if approved, this waiver will be valid for two years.

I acknowledge that the health plan I am using to waive University of Minnesota health plan coverage may not meet the recommended levels of benefit coverage that the Office of Student Health Benefits and the University of Minnesota advise residents and fellows to carry.

I acknowledge that by requesting this waiver from enrollment in the Resident and Fellow Health Benefit Plan I will not be eligible to request enrollment in the plan for the duration of the waiver except during open enrollment period or within 30 days of experiencing a qualifying event as outlined in the plan contract.

D. Resident/Fellow Acknowledgement

ACKNOWLEDGEMENT: I acknowledge that if approved, this waiver will be valid for two years. I understand that if I experience an involuntary loss of coverage during that period, I must enroll in the HealthPartners Residents and Fellows Health Plan within 30 days of my last date of coverage or wait to enroll at the next open enrollment period.

| | |
|--|-------------|
| Resident/fellow signature (electronic signatures are not accepted) | Date signed |
|--|-------------|

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

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