Student Health Benefit Plan
2016–2017 Enrollment and Change Form

Student Health Benefits
University of Minnesota
Driven to Discover℠

A. Primary Member Information

Name (last, first, middle initial) *(please print)* | Date of Birth (mm/dd/yyyy) | Gender | U of M ID Number

Street Address, City, State, ZIP Code | Daytime Phone | U of M E-mail Address

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

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

☐ 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 person to be covered

☐ Primary member, $999/semester ☐ One child, add $1,086/semester

☐ Spouse, add $1,476/semester ☐ Two or more children, add $1,554/semester

___ Initial to enroll dependents for both semesters. Option is only applicable fall semester and is contingent on verification by OSHB.

☐ 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 three dependents, please use the back of this form.

C. Payment Information – primary member premium will be billed to student account

Please choose payment method for dependents, if applicable.

☐ Bill my student account ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Method of Payment – credit card or student account | Home ZIP Code (if paying by credit card)

Account Number (if paying by credit card) | Expiration Date (if paying by credit card)

Authorizing Signature (electronic signatures are not accepted) | Date Signed

D. 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 Blue Shield 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

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