# Student Health Benefit Plan
# 2016–2017 International Scholar
# Enrollment and Change Form

**Student Health Benefits**
UNIVERSITY OF MINNESOTA
**Driven to Discover℠**

To enroll in the Student Health Benefit Plan or make changes to your enrollment, please complete and return this form to the Office of Student Health Benefits within 31 days of your arrival date at the University. Please keep a copy of this form for your records.

## A. Primary Member Information

Name (surname, given name, middle initial optional) *(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

Program: ☐ Scholar ☐ J-Intern ☐ Other_____

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 ☐ Recent arrival
☐ Make a change (name/address changes must be made in with the University before they can be changed in OSHB records.)

## B. Enrollment Information – please make plan selection and name all persons to be covered

| | |
|---|---|
| ☐ Primary member | $200/month |
| ☐ Spouse | $246/month |
| ☐ One child | $181/month |
| ☐ Two or more children | $259/month |
| ☐ Family | $723.75/month |

☐ Spouse _____
Name (surname, given name, middle initial optional) *(please print)* | Date of Birth | Gender | Social Security Number

☐ Child _____
Name (surname, given name, middle initial optional) *(please print)* | Date of Birth | Gender | Social Security Number

☐ Child _____
Name (surname, given name, middle initial optional) *(please print)* | Date of Birth | Gender | Social Security Number

If more than three dependents, please use the back of this form.

## C. 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

**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

Office of Student Health Benefits, 410 Church Street S.E., N323, Minneapolis, MN 55455. Email: umshbo@umn.edu.
Website: www.shb.umn.edu. Phone: 612-624-0627. Fax: 612-626-5183 or 1-800-624-9881.

# Student Health Benefit Plan 2016–2017 International Scholar Payment Form

Student Health Benefits
UNIVERSITY OF MINNESOTA
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## A. Scholar Information – please make a plan selection

| | |
|---|---|
| ☐ Primary member | $200/month |
| ☐ Spouse | $246/month |
| ☐ One child | $181/month |
| ☐ Two or more children | $259/month |
| ☐ Family | $723.75/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 or money order payable to the University of Minnesota for the total amount due is enclosed. Please charge my credit 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.

☐ My check or money order payable to the University of Minnesota for the total amount due is enclosed. I am aware that I must submit payment for the next month of coverage before the expiration date listed on my enrollment form.

☐ Please charge the total amount due to my credit card. Charge my credit 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.

☐ Please charge the total amount due above to my credit 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. Credit Card Information, if applicable

Name of International Scholar | U of M ID Number | Home ZIP Code

Credit Card – Choose one

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Name on Credit Card | Credit Card Account Number | Expiration Date

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

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