

# 2020-2021 Student Health Benefit Plan International Scholar Payment Form



Student Health Benefits  
UNIVERSITY OF MINNESOTA

## A. Scholar Information – please make a plan selection

Primary member	\$252/month
Spouse	\$313/month
One child	\$239/month
Two or more children	\$350/month
Family	\$915/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 (payable to the University of Minnesota) for the total amount due is enclosed or I am paying cash in person. Please charge my credit or debit card for my total monthly premium between the 15<sup>th</sup> and 20<sup>th</sup> of each month until I cancel coverage or provide written notification to discontinue charge authorization (automatic billing). Please call the Office of Student Health Benefits at 612-624-0627 to provide credit card information.

Charge the total amount due to my credit or debit card. Charge my credit or debit card for my total monthly premium between the 15<sup>th</sup> and 20<sup>th</sup> of each month until I cancel coverage or provide written notification to discontinue the charge authorization (automatic billing). Please call the Office of Student Health Benefits at 612-624-0627 to provide credit card information.

My check (payable to the University of Minnesota) for the total amount due is enclosed or I am paying cash in person. Please send me monthly payment coupons for subsequent check or cash premium payments.

I would like to pay the total amount by credit or debit card. Please call the Office of Student Health Benefits at 612-624-0627 to provide credit card information. Send me monthly payment coupons for subsequent premium payments to be made by check or cash.

## 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

Please submit to: Office of Student Health Benefits, 410 Church Street SE, N323, Minneapolis, MN 55455

Email: [umshbo@umn.edu](mailto:umshbo@umn.edu) Phone: 612-624-0627 Fax: 612-626-5183 or 1-800-624-9881 Website: [shb.umn.edu](http://shb.umn.edu)

Please keep a copy of this form for your records. ©2020 by the University of Minnesota, Office of Student Health Benefits