2020-2021 Student Health Benefit Plan
Short-term Coverage Extension Enrollment Form

Student Health Benefits
University of Minnesota

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 email address

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

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

Primary member, $212
One child, **add** $239
Spouse, **add** $313
Two or more children, **add** $350

Spouse ______________________________
Name (last, first, middle initial) *(please print)* | Date of Birth | Gender

Child ______________________________
Name (last, first, middle initial) *(please print)* | Date of Birth | Gender

Child ______________________________
Name (last, first, middle initial) *(please print)* | Date of Birth | Gender

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

C. Payment Information

Bill my student account

Credit card (to pay by credit card, please call the Office of Student Health Benefits at 612-624-0627)

Mail check

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 and Blue Shield of Minnesota 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

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