INSURANCE FORMS

for J-1 Scholars and Dependents

U of MN J-1 scholars are required to have U of MN health insurance or be officially waived by the Office of Student Health Benefits (OSHB). Exceptions are limited. Hosting departments of J-1 scholars are to print the appropriate insurance form and send it to the scholar for pre-arrival enrollment of the Student Health Benefit Plan (SHBP) for scholars. Sending insurance forms to scholars prior to their arrival helps communicate the U of MN policy, as well as, the costs and coverage associated with the insurance options. Scholars may also obtain and submit these forms upon their arrival at the U of MN. Pre-enrollment is a courtesy, not a requirement.

Print the below form(s) appropriate to the J-1 scholar’s situation:

1. **Enrollment, Change and Cancel Form**
   - Print this form and send to the scholar if they will not receive U of MN employee benefits. This form will begin their enrollment in the SHBP. Scholar will complete SHBP enrollment by submitting the Scholar Payment Form (below).

2. **Scholar Payment Form**
   - Print this form and send to the scholar if they will be enrolled in the SHBP and are expected to cover the costs for the insurance themselves.

3. **Department Authorization Form**
   - Print this form, complete, and submit to OSHB if the scholar will be enrolled in the SHBP and your department chooses to cover the insurance costs.

4. **Waiver Request Form**
   - Print this form and send to scholar if the scholar will receive U of MN employee benefits (such as, UPlan) or another U.S.-based employer-sponsored group health plan.

Please direct questions about:

- these forms and the SHBP to the OSHB
- employee benefits and eligibility to Office of Human Resources
- J-1 federal insurance regulations to ISSS
A. Primary Member Information

<table>
<thead>
<tr>
<th>Name (last, first, middle initial)</th>
<th>(Please Print)</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Gender</th>
<th>U of M ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address, city, state, ZIP code</td>
<td>Daytime phone</td>
<td>UMN E-mail address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

What would you like to do?  ____ Enroll Myself  ____ Enroll Dependent(s)  ____ Other

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 MyU 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

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

___ Spouse

<table>
<thead>
<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>(Please Print)</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

___ Child

<table>
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<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>(Please Print)</th>
<th>Date of Birth</th>
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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 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
Student Health Benefit Plan
2015-2016 International Scholar
Payment Form

You must enclose method of payment for the first two months of Scholar and Dependent Coverage (if applicable) with this form. You may select the option to pay subsequent payments by credit card automatically, or pay in person at the Office of Student Health Benefits. Payment is due no later than the due date listed on this form. Failure to remit payments by the payment due date will result in interruption or loss of coverage.

A. Scholar Information – please make a plan selection

<table>
<thead>
<tr>
<th>Scholar &amp; Family SHBP</th>
<th>Member Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Member</td>
<td>$200/month</td>
</tr>
<tr>
<td>Spouse</td>
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</tr>
<tr>
<td>Family</td>
<td>$723.75/month</td>
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</tbody>
</table>

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

Visa     Mastercard        Discover        American Express

Credit Card—CHECK ONE

Home Zip Code

Name on Credit Card

Credit Card Account Number

Expiration Date

Authorizing Signature (electronic signatures are not accepted)

Date Signed

Please submit to: Office of Student Health Benefits, 410 Church Street S.E., N323, Minneapolis, MN 55455. Fax: 612-626-5183 or 1-800-624-9881.
Please keep a copy of this form for your records. For more information, visit the Office of Student Health Benefits website at www.shb.umn.edu.

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International Scholars are required to enroll in the University-sponsored Student health Benefit Plan. If their appointing department wishes to cover the cost of the plan this form must be completed and submitted to the Office of Student Health Benefits within 31 days of the scholar’s arrival at the University of Minnesota. Payments must be made in full and partial payments will not be accepted.

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</table>

A. International Scholar Information

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<th>Gender</th>
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</thead>
<tbody>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td>Daytime Phone</td>
<td>Email Address</td>
<td></td>
</tr>
</tbody>
</table>

Department

This form to pay for: ___ Scholar ___ Dependent of a Scholar

B. Payment Information—this section must be completed in order for form to be processed

<table>
<thead>
<tr>
<th>Account string (EFS number) to be charged</th>
<th>Eight digit project code (only applies to projects with a sponsored activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount to be charged</td>
<td>Months covered (must be between 9/1/2015 and 8/31/2016)</td>
</tr>
</tbody>
</table>

C. Department Contact

<table>
<thead>
<tr>
<th>Name (Last, First, Middle Initial) (Please Print)</th>
<th>Campus address</th>
<th>Daytime Phone</th>
<th>Email Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Department Contact Signature</th>
<th>Date Signed</th>
</tr>
</thead>
</table>

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

<table>
<thead>
<tr>
<th>Effective Date of Change</th>
<th>Department</th>
<th>Approved By</th>
<th>Date Approved</th>
</tr>
</thead>
</table>

Please submit to: Office of Student Health Benefits, 410 Church Street S.E., N323, Minneapolis, MN 55455. Fax: (612) 626-5183 or 1-800-624-9881. Please keep a copy of this form for your records. For more information, visit the Office of Student Health Benefits website at www.shb.umn.edu. ©2015 by the University of Minnesota, Office of Student Health Benefits.
Student Health Benefit Plan
2015-2016 International Scholar
Waiver Request Form

International scholars are required to enroll in the University-sponsored Student Health Benefit Plan for International Scholars unless they are already enrolled in a United States-based employer-sponsored group health plan or the University-sponsored Graduate Assistant Health Plan.

To request a waiver from the University-sponsored Student Health Benefit Plan, submit this form to the Office of Student Health Benefits along with proof of coverage. All eligible scholars must complete the waiver request process within 31 days of their arrival in the United States. Please keep a copy of this form for your records.

A. Scholar 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 Email Address

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

B. Health Plan Information—which type of health plan do you have?

___ A United States-based employer-sponsored group health plan—Scholars who select this options must also submit proof of coverage such as a copy of the front and back of your insurance card or a certificate of credible coverage obtained from your insurance company.

___ University-sponsored Graduate Assistant Health Plan—Proof of coverage does not need to be submitted by scholars on this plan.

C. Acknowledgment

ACKNOWLEDGMENT: I understand that waivers are granted based on the health plan information provided along with this waiver request form. If my health plan situation changes I need to contact the Office of Students health Benefits within 31 days to notify them of the change.

CONFIDENTIALITY STATEMENT: This communication is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agents responsible for delivering the communication, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify us by telephone and return the communication to us at the below address via the U.S. Postal Service.

Scholar Signature (electronic signatures are not accepted) Date Signed

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Coverage Verified By Date Verified Approved By Date Approved

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