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

Updated Dec. 2013
International Student and Scholar Services
University of Minnesota

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 1-800-624-988.
Please keep a copy of this form for your records. ©2016 by the University of Minnesota, Office of Student Health Benefits.

Student Health Benefit Plan
2016–2017 International Scholar Payment Form

Student Health Benefits
UNIVERSITY OF MINNESOTA
Driven to Discover℠

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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Student Health Benefit Plan
2016-2017 International Scholar
Department Authorization Form

Student Health Benefits
UNIVERSITY OF MINNESOTA
Driven to Discover℠

International Scholars are required to enroll in the University-sponsored Student Health Benefit Plan (SHBP). 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.

Scholar & Family SHBP	Member Payment
Primary Member	$200/month
Spouse	$246/month
One Child	$181/month
Two or More Children	$259/month
Family	$723.75/month

A. International 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

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

Account String (EFS number) to be Charged Eight Digit Project Code (only applies to projects with a sponsored activity)

Amount to be Charged Months Covered **(must be between 9/1/2016 and 8/31/2017)**

C. Department Contact

Name (last, first, middle Initial) *(please print)*

Campus Address Daytime Phone Email Address

Department Contact Signature Date Signed

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Effective Date of Change Department Approved By Date Approved

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 1-800-624-988.
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