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

2020-2021 Student Health Benefit Plan
International Scholar Enrollment and Change Form

Student Health Benefits
University of Minnesota

To enroll in the Student Health Benefit Plan or make changes to your enrollment, please complete and return this form along with all other applicable documents 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, first, middle initial) *(please print)* | Date of birth (mm/dd/yyyy) | Gender | U of M ID number

Street address | Apt/Unit/Room # | City | State | ZIP code | U of M email 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 ☐ Recent arrival

☐ Cancel coverage for dependent(s) listed ☐ Cancel all coverage

☐ Make a change (name/address changes must be made 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	$252/month	☐ Two or more children	$350/month
☐ Spouse	$313/month	☐ Family	$915/month
☐ One child	$239/month		

☐ Spouse

Name (surname, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

☐ Child

Name (surname, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

☐ Child

Name (surname, first, middle initial) *(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 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

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 Phone: 612-624-0627 Fax: 612-626-5183 or 1-800-624-9881 Website: shb.umn.edu

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 on the 10th or 25th of each month until I cancel coverage or provide written notification to discontinue charge authorization (automatic billing).
- ☐ Charge the total amount due to my credit or debit card. Please charge my credit or debit 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 (automatic billing).
- ☐ My check (payable to the University of Minnesota) for the total amount due is enclosed or I am paying cash in person. I am aware that I must submit payment for the next month of coverage before the expiration date listed on my enrollment form.
- ☐ Charge the total amount due to my credit or debit 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. Card Information (if applicable)

Name of international scholar _____ U of M ID number _____

Credit/debit card – choose one

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on card _____ Card number _____ Expiration date _____

Authorizing 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 _____

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

2020-2021 Student Health Benefit Plan
International Scholar Department Authorization Form

Student Health Benefits
University of Minnesota

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, along with an enrollment form and all other applicable documents, 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.

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 | Unit/Apt/Room | City | State | ZIP code | U of M email address

Department

This form is to pay for: ☐ **Scholar** ☐ **Dependent of a Scholar**

B. Payment Information – this section must be completed for the form to be processed

☐ Primary member	$252/month
☐ Spouse	$313/month
☐ One child	$239/month
☐ Two or more children	$350/month
☐ Family	$915/month

Account string (EFS number)* to be charged
***Please ensure EFS account string is active for 2020-2021 fiscal year**

Eight digit project code (only applies to projects with a sponsored activity)

Amount to be charged

Months covered **(must be between 9/1/2020 and 8/31/2021)**

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

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

2020-2021 Student Health Benefit Plan
International Scholar Waiver Request Form

Student Health Benefits
University of Minnesota

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

To request a waiver from the SHBP, submit this form to the Office of Student Health Benefits along with proof of other 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 (surname, first, middle initial) *(please print)* | Date of birth (mm/dd/yyyy) | Gender | U of M ID number

Street address | Apt/Unit/Room # | City | State | ZIP code | U of M 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 option 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 dependent** – Proof of coverage does not need to be submitted by scholars on this plan. Please provide primary ID #:_____.

☐ **Graduate Assistant Health Plan Continuation of Coverage** – 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

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