

STUDENT HEALTH BENEFIT PLAN WAIVER/REFUND REQUEST

DIRECTIONS—If you are a degree-seeking student (6 or more credits; 3 or more credits during May/summer term), log into the Health Plan Coverage quick link or complete the Student Health Benefit Plan Waiver/Refund Request prior to the end of the second week of the term.

You may be exempt from coverage if you have:

- any employer-sponsored group plan
- family insurance coverage
- an individual plan with:
 - a maximum of a \$1,000 individual deductible
 - active coverage for the entirety of each term
 - no pre-existing condition exclusions
 - coverage for mental health and substance abuse services
 - a network provider facility within 50 miles of the on-campus health service
 - prescription drug coverage

The Student Health Benefit Office can electronically verify the following plans: Blue Cross and Blue Shield of Minnesota; Dean Health Plan; HealthPartners; Medica; MN Care or Medical Assistance; Preferred One; UCare; United Healthcare; Wisconsin Physician Services; Indian Health Services; Graduate Assistant Health Plan.

If you are not covered by one of the plans listed above, you can not use this form to waive the University-sponsored health plan.

You must go to <http://www.shb.umn.edu/waiver/index.htm> for instructions to waive the plan.

The information you provide is subject to periodic audits. Inaccurate or false information is a violation of the Student Conduct Code and may result in unexpected charges to your student account.

To ensure privacy online, open in Adobe Reader (free at Adobe.com). Please add the required signature(s) in blue or black ink.

RETURN THIS FORM:

By mail to

One Stop Student Services
 University of Minnesota, Twin Cities
 333 Science Teaching & Student Services
 222 Pleasant St. S. E.
 Minneapolis, MN 55455-0239

In person on campus to

333 Science Teaching & Student Services
 130 West Bank Skyway
 130 Coffey Hall

By fax to

612-625-3002

Questions?

Phone: 612-624-1111
 TTY (hearing-impaired): 612-626-0701
 Email: onestop@umn.edu

PART 1. Student background		
Name (last, first, middle initial)	University ID	
Current term of enrollment covered by private health plan <input type="checkbox"/> fall semester <input type="checkbox"/> spring semester <input type="checkbox"/> May/summer session	Year 20 ____	
<input type="checkbox"/> I have health insurance coverage that meets waiver requirements through an electronically verifiable plan (listed above).		
Name of insurance company	Member number	Group number
<input type="checkbox"/> I have applied for or am enrolled in the University-sponsored Graduate Assistant Health Plan		
PART 2. Certification		
I understand that the health plan information I provide is subject to periodic audits, and if found to be inaccurate or false, I may be subject to unexpected charges and be in violation of the Student Conduct Code. I agree to update my health plan information per University guidelines.		
<i>My signature below certifies that the information I have provided on this form is true and accurate to the best of my knowledge.</i>		
Student's signature	Date	

IMPORTANT: You must add your signature in PART 2 above or your form will not be processed.



The University of Minnesota is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation. This form is available in alternative formats upon request. Please call the One Stop liaison for Disability Services at 612-625-9578.

