Student Health Benefit Plan
2011-2012 International Student
Waiver Request Form

International students are required to enroll in the University-sponsored Student Health Benefit plan 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 students must complete the waiver request process by the Twin Cities campus class registration deadline (this deadline can be found on the One Stop website). Please keep a copy of this form for your records.

A. Student Information

<table>
<thead>
<tr>
<th>Name (Last, First, Middle Initial) (Please Print)</th>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Gender</th>
<th>U of M ID Number</th>
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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—Students 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—Proof of coverage does not need to be submitted by students on this plan.

___ In residence in my home country—Students who select this option must also submit proof of residence such as a copy of your flight ticket/itinerary showing departure from the United States and arrival in home country, or a copy of your passport showing stamped entry date into your home country.

C. Acknowledgment

ACKNOWLEDGMENT: I understand that waivers are granted on a semester basis and that a waiver request form will need to be submitted every semester by the Twin Cities class registration deadline in order to keep my waiver active. 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.

Student Signature          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 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.