

Student Health Benefit Plan

2010-2011 Morris Campus Change, Cancel, Payment, and Dependent Enrollment Form

Student Health Benefits

UNIVERSITY OF MINNESOTA

Driven to DiscoverSM

To enroll dependents in the Student Health Benefit Plan, please complete and return this form to The Office of Student Health Benefits before the Twin Cities campus class registration deadline (listed on the One Stop website). Please keep a copy of this form for your records.

A. Primary Member Information

Name (Last, First, Middle Initial) *(Please Print)* Date of Birth (mm/dd/yyyy) Gender U of M ID Number Social Security Number

Street Address, City, State, Zip Code Daytime Phone Email Address

What would you like to do? Enroll dependent(s): ___ due to birth/adoption ___ due to marriage ___ due to other coverage termination
 ___ Enroll myself ___ Make a change ___ Cancel coverage for dependent(s) listed ___ Cancel all coverage

B. Enrollment Information—please make plan selection and name all persons to be covered

___ Spouse/SSDP* \$1,122.00/semester
 ___ One Child \$870.00/semester
 ___ Two or More Children \$1,164.00/semester

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

___ Spouse/SSDP* _____
 Name (Last, First, Middle Initial) *(Please Print)* Date of Birth Gender Social Security Number

___ Child _____
 Name (Last, First, Middle Initial) *(Please Print)* Date of Birth Gender Social Security Number

___ Child _____
 Name (Last, First, Middle Initial) *(Please Print)* Date of Birth Gender Social Security Number

*Same-sex Domestic Partner

If more than two children, please use the back of this form.

C. Payment Information—please circle one

Visa Mastercard Discover American Express Bill my student account

Method of Payment—Credit Card or Student Account Home Zip Code (if paying by Credit Card)

Account Number (if paying by Credit Card) Expiration Date (if paying by Credit Card)

Authorizing Signature Date Signed

D. 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 my and/or my dependent's coverage.

Primary Member Signature Date Signed

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Total Cost Effective Date of Change Department Processed By Date Processed

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.