

# Health Plan Waiver Request

## 2012–2013 Medical School Residents and Fellows

University of Minnesota residents and fellows in job codes 9554, 9555, 9556, 9559, 9568, 9569, 9582, 9583 are required to have health plan coverage. If you do not want to enroll in the residents and fellows HealthPartners plan, you must complete this waiver form and prove that you have other insurance coverage as outlined in section B.

Please complete and return this form to The Office of Student Health Benefits. All eligible residents and fellows must complete the waiver request process by **June 15, 2012**, or within 14 days of their start date, whichever is later. Please keep a copy of this form for your records.

### A. Resident/Fellow 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

### B. Alternate Health Plan Information—indicate which type of coverage you have

- A United States-based employer-sponsored group health plan
- Minnesota Care

### C. Alternate Health Plan Information—additional documentation required

Contact your health insurance provider and request a certificate of coverage. Submit your certificate of coverage to the Office of Student Health Benefits along with this health plan waiver request form. The Office of Student Health Benefits cannot accept insurance cards as verification of insurance coverage.

I understand I must submit a certificate of coverage from my health insurance provider to the Office of Student Health Benefits to be considered for waiver.

### D. Resident/Fellow Acknowledgement

**ACKNOWLEDGEMENT:** I acknowledge that if approved, this waiver will be valid for two years. I understand that if I experience an involuntary loss of coverage during that period, I must enroll in the HealthPartners Residents and Fellows Health Plan within 60 days of my last date of coverage or wait to enroll at the next open enrollment period.

Resident/fellow signature (electronic signatures are not accepted)

Date signed

### FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Effective date of change

Approved by

Date approved