AHC Student Health Benefit Plan
2013–2014 Waiver Request Form

Student Health Benefits
University of Minnesota
Driven to Discover℠

To request a waiver from the University-sponsored AHC Student Health Benefit Plan, submit this form to the Office of Student Health Benefits along with proof of insurance coverage in the form of a **certificate of coverage**, also called a **letter of active coverage**, obtained from your insurance company (a copy of your insurance card is not acceptable verification of coverage to obtain a waiver). All eligible students must complete the waiver request process by the registration deadline each term (this date can be found on the One Stop website at onestop.umn.edu).
Please keep a copy of this form for your records.

A. Student Information

Name (last, first, middle initial) *(Please print)* ____ Date of birth (mm/dd/yyyy) ____ Gender ____ U of M ID number ____

Street address, city, state, ZIP code ____ Daytime phone ____ UMN E-mail address ____

Campus (check one): ○ Crookston ○ Duluth ○ Morris ○ Rochester ○ Twin Cities

B. 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.

Students with **VA Health Care** should submit a copy of the front and back of their VA card. Certificate of coverage is not required.
Students with **TriCare** should submit a copy of the front and back of their TriCare card or military ID. Certificate of coverage is not required.
University-sponsored Graduate Assistant Health Plan—Proof of coverage does not need to be submitted by students on this plan.

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

C. Acknowledgment *(please initial)*

____**I acknowledge** that if approved, this waiver will be valid for two years.
____**I acknowledge** that the health plan I am using to waive University of Minnesota health plan coverage may not meet the recommended levels of benefit coverage that the Office of Student Health Benefits and the University of Minnesota advise students to carry. Out-of-pocket health care costs related to deductibles, non-covered, or out-of-network services could place participation in my academic program at risk if required healthcare services are not obtained or not paid for.
____**I acknowledge** that by requesting this waiver from enrollment in the AHC Student Health Benefit Plan I will not be eligible to request enrollment in the plan for the duration of the waiver except during the fall open enrollment period or within 31 days of experiencing a qualifying event as outlined in the plan contract.
____**I acknowledge** that failure to submit both the completed waiver request form and certificate of coverage by the deadline will result in enrollment in and billing of the AHC Student Health Benefit Plan to be permanent for the semester.
____**I acknowledge** that the information provided with this form is subject to audit. If my coverage is found to be unverifiable and I fail to provide proof of active coverage related to my initial application within 30 days of notice from the Office of Student Health Benefits I will be enrolled in and billed for the AHC Student Health Benefit Plan the following semester.

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 (electronic signatures will not be accepted) ____ Date signed ____

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Date | Approved by | Supervisor initials (if necessary) | Claims check | Pharmacy check | Approved/denied?

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.
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