Student Health Benefits
UNIVERSITY OF MINNESOTA
Driven to Discover℠

Health Plan Waiver Request
2015–2016 Medical School Residents & 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, 2015**, 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 | E-mail address

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.

☐ 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.

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 residents and fellows to carry.
____I acknowledge that by requesting this waiver from enrollment in the Resident and Fellow Health Benefit Plan I will not be eligible to request enrollment in the plan for the duration of the waiver except during open enrollment period or within 30 days of experiencing a qualifying event as outlined in the plan contract.

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

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.