

Request to Add Health Insurance to the Cost of Attendance

The University of Minnesota requires all students enrolled for six or more credits in a degree program to have health insurance coverage. The purpose of this request is to consider the cost of purchasing health insurance coverage for those students not covered under parents', spouse's, or employer's health care plans. Allowable costs will be added to the cost of attendance calculation. Coverage must be billed to the student's account or purchased before it will be considered.

The cost of health insurance adjustment to the student's budget will not affect eligibility for federal, state, or campus-based grants or scholarships. Typically, any additional financial aid will be in the form of a federal, state, or alternative loan from a private lender, subject to the conditions of that loan program.

If this request is approved, additional loan funds will be offered to the student. A direct reimbursement is not made to the student or parent, and federal, state, or campus-based grants will not increase.

Complete this form in Adobe Reader software, not a Web browser, to ensure the privacy of your information. Place the cursor in a field and type. Print a copy to add the required signature(s) in blue or black ink.

Return this form on campus to:

Student Assistance Center
23 Solon Campus Center

or mail it to:

Office of Financial Aid and Registrar
University of Minnesota Duluth
1049 University Drive
Duluth MN 55812-3011

E-mail: umdhelp@d.umn.edu

Phone: 218-726-8000

Student information		
Last name—type or print neatly in ink	First	Middle
Student ID number	U of M e-mail @d.umn.edu	

Current career

- Undergraduate Graduate Professional (Medical School, College of Pharmacy, etc.)

Period of health insurance coverage for (specify one):

- Fall and Spring Fall only Spring only May and Summer Sessions

Type of health insurance purchased

- Academic Health Center (AHC) Student Health Plan
- Student Health Benefit Plan (SHBP)
- I have purchased health insurance from a provider other than the University of Minnesota plan. I have attached documentation of the provider, dates of coverage, and cost of the plan.

Certification

I certify that I have made the above purchase. I understand that if I elect to cancel this coverage for the specified student, I am obligated to inform the Office of Financial Aid and Registrar

Student signature

Date



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To request copies of this form in an alternative format: 218-726-8000.
UMD is an equal opportunity employer and educator.

http://www.d.umn.edu/fareg/forms/healthinsurance_2010.pdf

09/19/09