STUDENT HEALTH BENEFIT PLAN
CROOKSTON ENROLLMENT/CHANGE FORM

Blue Cross and Blue Shield of Minnesota Group EP489-10 & 11

For Domestic Students

Use this form to enroll, indicate changes to your member information or add/delete dependents.

Term (circle one): Fall Spr Sum Year _____

A. STUDENT INFORMATION

First Name | Last Name | EMAIL:

Street Address | Apt. No. | City | State | Zip Code

Today's Date | Student I.D. Number | Birthdate | Phone Number

B. FAMILY INFORMATION

Please choose type of plan:

Cost (per semester)

[ ] Student Only …… $680.00
[ ] *Spouse Only…… $898.00
[ ] Single Child Only…….. $760.00
[ ] Two or more Children…… $922.00
[ ] Family Coverage…… $1,820.00
(Family coverage is defined as a spouse and two or more children)

* or eligible same-sex domestic partner

*List all family members to be covered. Write names as they should appear on I.D. Card

	First Name	M.I.	Last Name	Gender	Birthdate	Social Security Number
1				M F		
2				M F		
3				M F		
4				M F		

♦ **Note: Enrollment form and payment must be submitted to our office every semester by the enrollment deadline for dependent(s)**

C. CHANGE IN COVERAGE

1. Additions [ ] Birth [ ] Marriage [ ] Adoption [ ] Other (please specify)

2. Termination [ ] Cancel all coverage (including self) [ ] Delete dependents listed

Reason [ ] Appointment terminated [ ] Student ineligible [ ] Other: [ ] Moved outside service are [ ] Dependent ineligible [ ] Death

*List all family members to be added,changed,or deleted

D. STUDENT CHANGES

1. Change address to:

2. Change Name from: to:

E. PAYMENT AND SIGNATURE (FORM MUST BE SIGNED AND DATED)

Method of payment: □ **Check #_____** □ **Bill Student Account Receivable** □ **Other (specify) _____**

□ **Major Credit Card**

Acct number: _____ - _____ - _____ - _____ Exp date: /

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 of Minnesota, 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 Student I.D. Number for the purpose of identification. The information procided 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.

X _____

Student Signature | Date Signed

F. FOR STUDENT HEALTH BENEFITS OFFICE USE ONLY

Effective Date of Coverage | Coverage terminate on | Approved by (signature) | Date

Please send enrollment forms with payment to:

Student Health Benefits Office
Boynton Health Service
410 Church Street S.E.; Room N323
Minneapolis, MN 55455
Fax: 612-626-5183 OR 1-800-624-9881(out of area) Phone: 612-624-0627 OR 1-800-232-9017 (out of area)

Original Copy - SHBP Office | Photocopy -Student