



Health Insurance Release Form for Dependents of F-1 students

I _____, SCSU ID# _____
(print full name)

plan to bring the following dependents to join me in St. Cloud, MN:

Dependent 1: _____ [] Spouse [] Child
Name
Dependent 2: _____ [] Child
Name
Dependent 3: _____ [] Child
Name
Dependent 4: _____ [] Child
Name

Select one:

- I plan to enroll my dependent(s) in the MnSCU Health Insurance plan administered by Health Services at St. Cloud State University. The charge for a spouse (if applicable) is \$2,752/year and the charge for each child (if applicable) is \$1,693/year. **I understand that I must contact the Center for International Studies annually to continue health insurance coverage for my dependents.**
- I **do not** plan to enroll my dependent(s) into the MnSCU Health Insurance plan. I understand that as an F-1 student, I am not required to purchase the MnSCU Health Insurance for my dependent(s). **I will be responsible for all medical and/or dental costs while they are in the United States should we not purchase MnSCU Health Insurance. Under no circumstances is St. Cloud State University responsible for any medical and/or dental costs that my dependent(s) incur while in the United States.**

I have read and understand the above statement.

Student Signature

Date

