



HEALTH INSURANCE RELEASE FORM Dependents of F-1 students

I _____, SCSU ID# _____
(Please print)

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

[] I plan to enroll my dependent(s) into the MnSCU Health Insurance plan administered by Health Services at St. Cloud State University. The charge for a spouse (if applicable) is \$2,901/year and the charge for each child (if applicable) is \$1,784/year.

[] 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

Please return this form to the Center for International Studies at 101 Lawrence Hall, 720 4th Avenue South, St. Cloud, MN 56301 or by fax at 320-308-4223.