Health Insurance Release Form for F-1 Students

Please allow 5 full business days for processing a complete application

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

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

Dependent 1: _____ [ ] Spouse [ ] Child
(Last name, First name)
Dependent 2: _____ [ ] Child
(Last name, First name)
Dependent 3: _____ [ ] Child
(Last name, First name)
Dependent 4: _____ [ ] Child
(Last name, First name)

Select one:

____ I plan to enroll my dependent(s) in the MnSCU Health Insurance plan, UnitedHealthCare StudentResources, administered by Health Services at St. Cloud State University.

- I understand that I am responsible for submitting the enrollment form found at: https://www.uhcsr.com/stcloudstate and paying the required premium payment directly to UnitedHealthCare StudentResources.
- I understand that I must contact the UnitedHealthCare StudentResources annually to continue health insurance coverage for my dependents.

____ I **do not** plan to enroll my dependent(s) into the MnSCU Health Insurance plan, UnitedHealthCare StudentResources, administered by Health Services at St. Cloud State University.

- I understand that as an F-1 student, I am not required to purchase the MnSCU Health Insurance for my dependent(s).
- I understand that I am responsible for all medical costs while they are in the United States should we not purchase the MnSCU Health Insurance plan. Under no circumstances is St. Cloud State University responsible for any medical costs that my dependent(s) incur while in the United States.

By signing below, I certify that the above information is true and correct to the best of my knowledge.

Student Signature: _____ Date: _____

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