Minnesota State Colleges and Universities
Student Health Insurance Petition for Refund
2024 - 2025 Academic Year

Campus:

- ☐ Bemidji State University
- ☐ Metropolitan State University
- ☐ Minnesota State University, Mankato
- ☐ Minnesota State University, Moorhead
- ☐ St. Cloud State University
- ☐ Southwest State University
- ☐ Winona State University
- ☐ MN Community/Technical College: Name of Campus: _____

PLEASE PRINT CLEARLY:

Name (Last) _____ Name (First) _____

Date of Birth_____ Student ID# _____ Phone #_____

Please allow up to 6 weeks for your refund request to process. Please provide a physical U.S. address that you, or a trusted family member or friend, will have access to for the next 6 weeks. Please write clearly or electronically type in address. If your address is not legible, you will not receive your refund.

_____
_____
_____
_____

Please read the following and check the appropriate box:

- ☐ I have graduated and either applied for OPT or plan to leave the U.S. within 60 days of my graduation date.
- ☐ I am no longer enrolled because I transferred to another college/university*
- ☐ I left the United States and will not return to this college/university within the next year. Date of departure: _____
- ☐ I am no longer in F or J immigration status and am not required to purchase student health insurance (must show form I-797 Notice of Approval from USCIS , I-551 Permanent Resident Card, or other document verifying approved change of status)

To the student:

By signing below, I am verifying that the above statement is true. I understand that I am no longer required to maintain MnSCU student health insurance. Under no circumstances is the college/university responsible for any of my medical or dental bills incurred during such coverage or after it is no longer in effect. Once I terminate my insurance, I understand that I cannot re-enroll in coverage, and I will be solely responsible for all medical and/or dental bills.

I acknowledge that my insurance coverage will end on the last day of the month in which I submit and sign this form, unless I leave the U.S. in which case my coverage will end on the day I depart the U.S. (as long as this form has been submitted).

Signature of Student _____ Date _____

International Student Advisor Approval _____ Date _____

Advisor Name and Title _____

Comments _____

***If you are transferring to another MN State College/University you should maintain student health insurance.** You will continue to receive insurance benefits for existing claims or claims that may occur in the quarters/semesters that you do not attend the college/university. If you do not continue coverage and a break in coverage occurs, you must wait one year or longer to receive benefits for any pre-existing condition.

Note: Refunds are calculated from the date the insurance company is notified to drop the coverage using this completed form. Please allow up to six weeks for the refund to be processed. If you have not received your refund after six weeks you may call United Healthcare Student Resources at 1-888-251-6243. ***Please keep a copy of this form for your own record.*

STUDENT: YOU ARE RESPONSIBLE FOR SENDING THIS FORM TO THE KEARNEY INTERNATIONAL CENTER FOR PROCESSING

E-Mail: international@mnsu.edu

**This form requires signatures. If you are emailing this form, scan the signed document and send it as an attachment.*