UNIVERSITY OF MARYLAND
THE GRADUATE SCHOOL

Health Insurance Reimbursement Request Form

Please see policy for eligible students at http://www.gradschool.umd.edu/Fellowship/insurance.htm

Please provide the following information:

Name: _____ UID #: _____

Department: _____ Term: ☐AY ☐ Fall ☐ Spring/Summer
(Please circle one)

Type of fellowship (check one):

____ Departmental Block Grant Fellowship (full-time, no additional support)

____ Graduate School Fellowship (full-time, no additional support)

____ External Fellowship (full-time only, no additional support)

You must provide a copy of **your insurance card and proof of payment showing the amount paid. If you are an external fellow, a copy of your fellowship MOU must also be submitted to receive reimbursement.**

By my signature below, I attest that at the present time I do not participate in the UMCP State of Maryland Health Insurance Plan as a benefit of employment, nor am I covered by the insurance plan of a spouse or parent.

_____ _____
Signature of Applicant Date

_____ _____
Director of Graduate Studies Date

_____ _____ _____
Graduate School Designee Amount Reimbursed Date

Please send completed forms to Barbara Ferguson, The Graduate School, 2123 Lee Bldg.