



# HEALTH INSURANCE REIMBURSEMENT REQUEST FORM

Please refer to the Graduate School policy for [Health Insurance for Fellows](#) for eligibility requirements.

Please submit this form by going to <https://forms.gle/tn9K37eNuMWvMSj68>

## GENERAL INFORMATION:

NAME: \_\_\_\_\_ Student University ID Number (UID): \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

## TYPE OF FELLOWSHIP: (check one)

Dean’s Fellowships (\$12,500 in one semester, or \$25,000 in Fall and Spring, no additional support.)

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

Name of Fellowship \_\_\_\_\_

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

Name of Fellowship \_\_\_\_\_

## REQUIRED DOCUMENTS TO BE ATTACHED:

- Copy of Insurance Card
- Proof of payment clearly showing amount paid
- If external fellow, a copy of the fellowship MOU or agreement.

*By my signature below, I attest that at the present time, I do not participate in any State of Maryland health insurance plan offered by the University of Maryland as a benefit of employment.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director of Graduate Studies

\_\_\_\_\_  
Date

\_\_\_\_\_  
Graduate School Approver

\_\_\_\_\_  
Amount Reimbursed

\_\_\_\_\_  
Date