



## HEALTH INSURANCE REIMBURSEMENT REQUEST FORM

Please refer to the Graduate School policy for [Health Insurance for Fellows](#) for eligibility requirements.  
Completed form should be sent to Barbara McElroy-Ferguson, 2123 Lee Building or [baf@umd.edu](mailto:baf@umd.edu).

### REQUIRED INFORMATION:

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

DEPARTMENT: \_\_\_\_\_ TERM: AY    Fall    Spring/Summer  
(Please check one)

### TYPE OF FELLOWSHIP: (check one)

University or Dean’s Fellowship (full-time, 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, nor am I covered by the insurance plan of a spouse or parent.*

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

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

\_\_\_\_\_  
Date