



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, if an external fellow, a copy of your fellowship MOU 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.