2017-2018 Student Dental Plans Enrollment Form

Student Health Benefits
University of Minnesota

To request dental plan enrollment, please complete and return this form to the Office of Student Health Benefits by **September 27, 2017**. Please keep a copy of this form for your records.

If you are on the Student Health Benefit Plan (SHBP), you have preventive and periodontal dental coverage included in the SHBP. You have the option of enrolling in the Dental Buy-Up Plan which provides additional coverage for restorative and other services, for an added cost of $138 per semester.

If you are not on the SHBP, you can enroll in the Voluntary Student Dental Plan (VSDP). The VSDP includes preventive, periodontal and restorative coverage and is $228 per semester.

A. Enrollee Information

Name (last, first, middle initial) *(please print)* | Date of birth (mm/dd/yyyy) | Gender | U of M ID number

Street address, city, state, ZIP code | Daytime phone | Email address

Please select your campus: ☐ Crookston ☐ Duluth ☐ Morris ☐ Rochester ☐ Twin Cities

What would you like to do?

Students who are on the Student Health Benefit Plan:

☐ Request 2017-2018 fall and spring semester enrollment in the Buy-Up Dental Plan, $138 per semester

☐ Other (please explain): _____

Students who are not on the Student Health Benefit Plan:

☐ Request 2017-2018 fall and spring semester enrollment in the Voluntary Student Dental Plan, $228 per semester

☐ Other (please explain): _____

Please note: name and address changes must be made in MyU before they can be changed in OSHB records.

B. Authorization

ACKNOWLEDGEMENT OF YEAR-LONG COVERAGE: I understand coverage is issued on a yearly basis. I will be enrolled for fall and spring semesters.

AUTHORIZATION TO CHARGE STUDENT ACCOUNT: I hereby authorize and direct the University of Minnesota to place a charge on my student account for coverage noted above for one academic year. I understand that I am opting to purchase this plan for one year and that after the open enrollment period ends I will not have the option of exiting the plan until the plan year expires. I understand that I will see a charge on my student account once in fall semester, and another charge in spring semester to pay for my year-long dental coverage.

ACKNOWLEDGEMENT: The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by myself on this application may invalidate my coverage. I understand my U of M ID Number will be used for the purpose of identification with Delta Dental. When using this application I agree to transact business using electronic communications, electronic records, and electronic signatures rather than using paper documents.

Enrollee signature (electronic signatures are not accepted) | Date signed

Office of Student Health Benefits, 410 Church Street SE, N323, Minneapolis, MN 55455.
Email: umshbo@umn.edu. Website: www.shb.umn.edu. Phone: 612-624-0627. Fax: 612-626-5183 or 1-800-624-9881.