2018-2019 Student Dental Plans Enrollment Form

Student Health Benefits
University of Minnesota

To request dental plan enrollment, complete and return this form to the Office of Student Health Benefits.

If you are enrolled in 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 additional cost of $326 per plan year. Students who are enrolled both fall and spring semesters will be billed in two installments of $163.

If you are not enrolled in the SHBP, you can enroll in the Voluntary Student Dental Plan (VSDP). The VSDP includes preventive, periodontal and restorative coverage and is $496 per plan year. Students who are enrolled both fall and spring semesters will be billed in two installments of $248.

A. Primary Member 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 | U of M email address

Campus (check one): ☐ Crookston ☐ Duluth ☐ Morris ☐ Rochester ☐ Twin Cities

What would you like to do?

Students who are enrolled in the Student Health Benefit Plan:

☐ Request enrollment in the Buy-Up Dental Plan, $326

☐ Other (please explain): _____

Students who are not enrolled in the Student Health Benefit Plan:

☐ Request enrollment in the Voluntary Student Dental Plan, $496

☐ Other (please explain): _____

Name and address changes must be made with the University before they can be changed in OSHB records.

B. Authorization

ACKNOWLEDGEMENT OF COVERAGE TERM: I understand that I am opting to purchase this plan for the remainder of the academic year and that after the open enrollment period ends, unless I become ineligible, I will not have the option of exiting the plan until the plan year expires.

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. I understand 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.

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.

Primary member signature (electronic signatures are not accepted) | Date signed

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