2023-2024 Dental Plan Enrollment and Change Form
Graduate Medical Education Residents and Fellows

Optional enrollment for residents and fellows in job codes 9556, 9559, 9582, 9583, 9555, 9554, 9568 and 9569 and their dependents. To enroll in or make changes to your dental insurance, please complete and return this form to the Office of Student Health Benefits. All eligible residents and fellows must complete the enrollment process by June 15, 2023, or within 30 days of their start date, whichever is later. Please keep a copy of this form for your records.

A. Resident/Fellow Information

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

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

B. Enrollment Information – please make plan selection and name all persons to be covered or changed

What would you like to do? ☐ Enroll myself (and dependents, if applicable) ☐ Make a change

Open Enrollment/Status Change: After open enrollment closes, you can only make changes to your coverage during non-open enrollment periods due to a status change, see **shb.umn.edu** for a list of eligible status changes. During open enrollment (May 1 to June 15), you can change plans, add or cancel dependent coverage. Within 30 days of a family change, you can add or cancel dependent coverage.

☐ Resident/Fellow only – $10.51/pay period

☐ Resident/Fellow and family – $30.94/pay period

☐ Spouse _____
Name (last, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Gender | Social Security Number

If more than two children, please use the back of this form.

C. Resident/Fellow Acknowledgement

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the dental plan administrator or the University of Minnesota, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim. I also authorize on behalf of us the use of my U of M ID number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by us on this application may invalidate my and/or my dependent's coverage.
AUTHORIZATION TO DEDUCT COST OF PLAN FROM PAYROLL: I hereby authorize and direct the University of Minnesota to deduct from my stipend checks amounts to cover my insurance premiums while enrolled as a resident or fellow. Said deductions will be taken from each bi-weekly check. I understand that my department is authorized to make subsequent insurance premium adjustments at prevailing University of Minnesota rates as appropriate to my resident or fellow classification.

Resident/Fellow 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: shb.umn.edu
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