

2023-2024 Dental Plan Enrollment and Change Form

School of Dentistry Residents and Fellows

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Optional enrollment for residents and fellows in job codes 9552 and 9553 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) <i>(please print)</i>	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 – \$22.78/month

Resident/Fellow and family – \$67.03/month

Spouse	Name (last, first, middle initial) <i>(please print)</i>	Date of birth	Gender	Social Security Number
Child	Name (last, first, middle initial) <i>(please print)</i>	Date of birth	Gender	Social Security Number
Child	Name (last, first, middle initial) <i>(please print)</i>	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 CHARGE STUDENT ACCOUNT: I hereby authorize and direct the University of Minnesota to charge my student account at the beginning of each term for this coverage.

Resident/Fellow signature (electronic signatures are not accepted)	Date signed
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