

2023-2024 Medical Plan Enrollment and Change Form

School of Dentistry Residents and Fellows

Enrollment is required for residents and fellows in job codes 9552 and 9553. Enrollment is optional for your dependents. If you have other health insurance and do not want to enroll in the Residents, Fellows and Interns health plan, you must complete a waiver form. To enroll in or make a change, 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	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.

Basic Option

Resident/Fellow only – \$45.42/month
Resident/Fellow and Spouse – \$310.11/month
Resident/Fellow and Child – \$237.22/month
Resident/Fellow and Children – \$355.56/month
Resident/Fellow and Family – \$425.16/month

Basic Plus Option

Resident/Fellow only – \$113.61/month
Resident/Fellow and Spouse – \$586.45/month
Resident/Fellow and Child – \$446.81/month
Resident/Fellow and Children – \$673.18/month
Resident/Fellow and Family – \$827.39/month

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 health insurance 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 _____