# 2023-2024 Student Dental Buy-Up Plan
# OPT International Student Enrollment Form

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 $984.48 per plan year. Students who are enrolled both fall and spring semesters will be billed in two installments of $492.24.

To request Buy-Up Dental Plan enrollment, please complete and return this form to the Office of Student Health Benefits by **September 28, 2023**. Please keep a copy of this form for your records.

## 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?

☐ Request 2023-2024 enrollment in the Dental Buy-Up Plan, $984.48 per year (must be enrolled in the Student Health Benefit Plan)

☐ 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 YEAR-LONG COVERAGE**: I understand coverage is issued on a yearly basis. I will be enrolled for both the fall and spring semesters.

**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

## C. Select Payment Method

☐ Check

☐ Cash

☐ Credit/debit card (please provide card information below)

## D. Card Information (if applicable)

Credit/debit card – choose one

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on card | Card number | Expiration date

Authorizing 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