2024-2025 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, 2024, 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) | Sex | 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 – $58.77/month
- ☐ Resident/Fellow and Spouse – $393.85/month
- ☐ Resident/Fellow and Child – $301.51/month
- ☐ Resident/Fellow and Children – $454.18/month
- ☐ Resident/Fellow and Family – $550.18/month

Basic Plus Option

- ☐ Resident/Fellow only – $146.92/month
- ☐ Resident/Fellow and Spouse – $745.25/month
- ☐ Resident/Fellow and Child – $567.80/month
- ☐ Resident/Fellow and Children – $858.70/month
- ☐ Resident/Fellow and Family – $1,070.41/month

☐ Spouse _____
Name (last, first, middle initial) *(please print)* | Date of birth | Sex

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Sex

☐ Child _____
Name (last, first, middle initial) *(please print)* | Date of birth | Sex

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

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