2024-2025 Student Dental Buy-Up Plan 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 for coverage effective September 1, 2024 through August 31, 2025. Students who enroll in the fall semester will be automatically enrolled for the spring semester, if eligible, and billed in two installments of $492.24.

To request Dental Buy-Up Plan enrollment, please complete and return this form to the Office of Student Health Benefits by **September 26, 2024**. 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) | Sex | 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 2024-2025 enrollment in the Dental Buy-Up Plan (must be enrolled in 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 understand that I am opting to purchase this plan for one year (fall and spring semesters) and that after the open enrollment period ends, unless I become ineligible, I will not have the option of exiting the plan until the plan year expires.

AUTHORIZATION TO CHARGE STUDENT ACCOUNT: I hereby authorize and direct the University of Minnesota to place a charge on my student account for the Dental Buy-Up Plan. I understand that the cost of the plan is $984.48 and that I will see a charge of $492.24 on my student account if I was eligible for the Fall 2024 semester and another charge of $492.24 in the Spring 2025 semester, if eligible, to pay for my year-long dental coverage.

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

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