

# 2024-2025 Student Dental Buy-Up Plan OPT International Student Enrollment Form

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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 26, 2024**. Please keep a copy of this form for your records.

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## A. Primary Member Information

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Name (last, first, middle initial) <i>(please print)</i>	Date of birth (mm/dd/yyyy)	Sex	U of M ID number
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Street address, city, state, ZIP code	Daytime phone	U of M email address
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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, \$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.

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## 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.

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Primary member signature (electronic signatures are not accepted)

Date signed

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## C. Select Payment Method

Check

Cash

Credit/debit card (please provide card information below)

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## D. Card Information (if applicable – cannot be submitted via email)

Credit/debit card – choose one

Visa

MasterCard

Discover

American Express

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Name on card

Card number

Expiration date

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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](mailto:umshbo@umn.edu) | Phone: 612-624-0627 | Fax: 612-626-5183 or 1-800-624-9881 | Website: [shb.umn.edu](http://shb.umn.edu)

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