Voluntary Student Dental Plan
2015–2016 Enrollment, Change, and Cancel Form

Student Health Benefits
UNIVERSITY OF MINNESOTA
Driven to Discover℠

To request enrollment, make a change, or cancel your enrollment request, please complete and return this form to The Office of Student Health Benefits by the enrollment deadline listed online. Please keep a copy of this form for your records.

A. 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 | E-mail address

Please select your campus: ☐ Crookston ☐ Duluth ☐ Morris ☐ Rochester ☐ Twin Cities

What would you like to do?

☐ Request enrollment in the Voluntary Student Dental Plan

☐ Cancel Voluntary Student Dental Plan enrollment request

☐ Make a change

Please note: name and address changes must be made in MyU 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 fall and spring semesters.

AUTHORIZATION TO CHARGE STUDENT ACCOUNT: I hereby authorize and direct the University of Minnesota to place a charge on my student account for the Voluntary Student Dental Plan coverage for one academic year. I understand that I am opting to purchase this plan for one year and that after the open enrollment period ends I will not have the option of exiting the plan until the plan year expires. I understand that I will see a charge on my student account once in fall semester, and another charge once in spring semester to pay for my year-long Voluntary Student Dental Plan 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 MetLife. When using this application I agree to transact business using electronic communications, electronic records, and electronic signatures rather than using paper documents.

Member signature (electronic signatures are not accepted) | Date signed

FOR USE BY OFFICE OF STUDENT HEALTH BENEFITS

Total cost | Effective date of change | Term date | Processed by | Date processed

Please submit to: Office of Student Health Benefits, 410 Church Street S.E., N323, Minneapolis, MN 55455. Fax: 612-626-5183 or 1-800-624-9881.
Please keep a copy of this form for your records. For more information, visit the Office of Student Health Benefits website at www.shb.umn.edu.