USF HEALTH MORSANI COLLEGE OF MEDICINE

DENTAL & VISION ENROLLMENT VERIFICATION FORM

2019-2020

Residents are charged a monthly premium **for individual and dependent dental and vision coverage**. The amount you are billed will depend on the level of coverage that you elect. Once coverage is elected, premium deductions are automatically deducted from your pay.

To ensure that we have the correct information on your selected coverage, please complete the following information.

Resident Name: ____________________________ S.S. #________________
(Please print)

Please circle your selection:

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
DENTAL ELECTION				
Plan Name				
UHC DHMO	$17.20	$30.10	$37.28	$47.31
UHC Low Plan PPO 20	$22.92	$45.83	$57.49	$85.02
UHC High Plan PPO 30	$37.19	$74.36	$93.28	$137.95
VISION ELECTION				
Plan Name				
UHC Vision	$6.93	$13.15	$15.42	$21.69

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______________________________________ ________________________
Signature Date