

2022-2023 COBRA

Health Insurance Enrollment and Change Form

School of Dentistry Education Residents and Fellows

Optional enrollment for completing residents and fellows in job codes 9552 and 9553 and their dependents. At the end of your residency or fellowship, residents and fellows enrolled in the Residents, Fellows and Interns health benefits have the option to enroll in COBRA. You will be enrolled in the same level of benefits as you were enrolled in as a resident or fellow. COBRA enrollment must be completed within 60 days of your last day of coverage. You may stay enrolled in COBRA for up to 18 months continuously. 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) _____ Gender _____ 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

Basic Option

Resident/Fellow only – \$454.20/month
 Resident/Fellow and Spouse – \$1,348.30/month
 Resident/Fellow and Child – \$1,031.40/month
 Resident/Fellow and Children – \$1,545.90/month
 Resident/Fellow and Family – \$1,848.50/month

Basic Plus Option

Resident/Fellow only – \$546.40/month
 Resident/Fellow and Spouse – \$1,585.00/month
 Resident/Fellow and Child – \$1,207.60/month
 Resident/Fellow and Children – \$1,819.40/month
 Resident/Fellow and Family – \$2,236.20/month

Spouse _____
 Name (last, first, middle initial) *(please print)* _____ Date of birth _____ Gender _____ Social Security Number _____

Child _____
 Name (last, first, middle initial) *(please print)* _____ Date of birth _____ Gender _____ Social Security Number _____

Child _____
 Name (last, first, middle initial) *(please print)* _____ Date of birth _____ Gender _____ Social Security Number _____

If more than two children, please use the back of this form.

C. Qualifying Event – please indicate reason for COBRA application

Completion of residency or fellowship	Early termination of residency or fellowship
Eligible leave of absence	Death of covered employee
Change in employment status	Divorce from employee
Loss of eligibility as a dependent child (due to age)	

D. 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.

Resident/Fellow signature (electronic signatures are not accepted) _____

Date signed _____