2024-2025 COBRA
Dental Insurance Enrollment and Change Form
College of Veterinary Medicine Residents and Interns

Optional enrollment for completing residents and interns in job codes 9541, 9548, and 9549 and their dependents. At the end of your residency or internship, residents and interns enrolled in the Residents, Fellows and Interns dental 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 intern. 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/Intern 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 | Email address

B. Enrollment Information – please make plan selection and name all persons to be covered or changed

- ☐ Resident/Intern only – $23.90/month
- ☐ Resident/Intern and family – $67.03/month
  - ☐ Spouse ______________________
    Name (last, first, middle initial) *(please print)* | Date of birth | Sex
  - ☐ Child ______________________
    Name (last, first, middle initial) *(please print)* | Date of birth | Sex
  - ☐ Child ______________________
    Name (last, first, middle initial) *(please print)* | Date of birth | Sex

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 internship
- ☐ Early termination of residency or internship
- ☐ 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/Intern 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 dental plan 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/Intern 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
Please keep a copy of this form for your records.