2024-2025 COBRA
Life Insurance Enrollment and Change Form
Graduate Medical Education Residents and Fellows

Optional enrollment for completing residents and fellows in job codes 9556, 9559, 9582, 9583, 9555, 9554, 9568 and 9569 and their dependents. At the end of your residency or fellowship, those enrolled in Residents, Fellows and Interns life insurance 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) | Sex | U of M ID number

Street address, city, state, ZIP code | Daytime phone | Email address

Beneficiary | Relationship to insured

B. Enrollment Information – please indicate amount of insurance in increments of $5,000

Basic Life Insurance

☐ Resident/Fellow only – $3.15/month ($50,000 of insurance)

Supplemental Life Insurance

Rates for each $5,000 of insurance for Residents, Fellows, Spouse

Age	Monthly Rate
Under 30	$0.27
30-34	$0.31
35-39	$0.40
40-44	$0.66
45-49	$1.06

Age	Monthly Rate
50-54	$1.68
55-59	$2.10
60-64	$5.46
65-69	$8.88
70+	$22.39

Rates for each $5,000 of insurance for Child Life

Monthly Rate
$0.77

	Amount of Optional Life Terminating	Amount of Optional Life Being Converted	Monthly Cost of Supplemental Life Insurance
Residents and Fellows Optional Life	$_____	$_____	$_____
Spouse Life	$_____	$_____	$_____
Child Life	$_____	$_____	$_____

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 life 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

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