

2022-2023 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) _____ Gender _____ U of M ID number _____ Social Security 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

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

| 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 |

| 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

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