UPlan

Office of Human Resources
University of Minnesota
Driven to Discover®

COBRA – Request for Continuation of Coverage

Complete the following information no later than 60 days after the loss of coverage or the date of the COBRA notice, whichever is later. Be sure to provide current address for future billings. DO NOT SEND MONEY WITH THIS FORM. A monthly billing statement will be sent to you from the plan administrator, 121 Benefits. **Do not use this form if you are retiring from the University of Minnesota.**

Information on your individual applying for coverage *(please print)*

Last Name | First Name | MI | Employee ID Number *and* Social Security Number | Date of Birth *(MM/DD/YY)*

Current Home Address | City | State | Zip Code | Home Phone

Please complete if the employee is not applying for coverage.

Name of Employee | Employee ID number | Social Security number

Reason for Continuation of Coverage **Date of event:**_____

- ☐ Employment termination/layoff/paid U of M layoff
- ☐ Change in employment status
- ☐ Divorced spouse
- ☐ Death of employee
- ☐ Loss of eligibility

Medical Plan

I wish to continue my medical plan at the following coverage level.

☐ Applicant Only ☐ Applicant and Children ☐ Applicant and Spouse with or without Children

Dental Plan

I wish to continue my dental plan at the following coverage level.

☐ Applicant Only ☐ Applicant and Children ☐ Applicant and Spouse with or without Children

Life Insurance

(May be continued only if employee is applying for coverage in event of termination, layoff, or loss of eligibility)

Amount of Coverage

☐ Basic Employee Life $_____ ☐ Additional Employee Life $_____

☐ Spouse Life $_____ ☐ Child Life $10,000

Health Care Flexible Spending Account

☐ I wish to continue my current Health Care Flexible Spending Account on an after-tax basis for the remainder of the calendar year.

Dependent Information (complete if requesting coverage for additional individuals)

Medical	Dental	Name (Last, First, MI)	Date of Birth	Social Security Number
☐	☐	Spouse:		
☐	☐	Child:		
☐	☐	Child		

Authorization (Please read before signing)

I have reviewed the guidelines for continuation of coverage and understand them. I am applying for continuation of coverage through the University of Minnesota UPlan and University of Minnesota Health Care Flexible Spending Account, as indicated above, subject to approval of my eligibility. If eligible, I understand that coverage will be continued at my expense. I understand that my coverage will not be reinstated until the first premium payment is received by the coverage administrator. I authorize the disclosure of the information on this form to Total Compensation at the University of Minnesota and plan administrators for the use in determining my eligibility and in processing my application. This authorization is valid until revoked by operation of law.

Signature of individual applying for continuation: _____ **Date:** _____

(The employee or spouse must sign for the dependent in case of a minor)

Signature of Employee/Spouse: _____ **Date:** _____

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Information and Privacy – There are laws to protect your rights

Several state and federal laws aid in protecting your rights to privacy and make it easier for you to review information in your insurance file. Under one of these laws – the Minnesota Government Data Practices Act (Minnesota Statutes 13.01-13.43) – you have the right to know the following.

A. Why the Information is needed

The Information we request about you, your employment, and family members is needed for one or more of the following reasons:

- To determine whether you are eligible for University of Minnesota UPlan Health Program coverage
- To establish the amount of insurance coverage for which you are eligible
- To determine the amount of deductions from your paycheck to pay your rate contributions

B. Supplying Information – Your Rights

- **Minnesota Stature 13.04.** You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your application for coverage under the group plan.
- **Federal Privacy Act of 1974; Public Law 93-579.** Disclosure of your Social Security number is voluntary. The information is requested to identify your records in the Total Compensation system and the records of the Plan Administrators. While you are not legally required to furnish this information, processing of your application for group benefits will be delayed without it.

C. Who Uses the Information and How It Is Used

The information we collect will be used by University employees operating the group benefits program, the payroll system, federal and state tax authorities, and shared with the Plan Administrators involved in your benefits coverage. Depending on the coverage you request (and are eligible for), the information may be used to:

- Provide enrollment and/or change information to your Plan Administrators so they can provide benefits and pay claims
- Conduct quality improvement initiatives
- Prepare statistical reports and evaluate studies

When you are no longer an active participant in the group benefits program, your file is kept until state retention requirements are met.

D. What information You Can Access

You may request in writing to be shown information about yourself that is maintained by our department. There may be a charge if physical copies are needed.

If you have questions, call the OHR Contact Center at 612-624-8647 or 1-800-756-2363 Option 1 for Benefits, or by email at benefits@umn.edu.
Please make a copy of this form for your records and return the original by mail or fax.

Campus Mail:
Total Compensation
100 DonhoweB
Del Code 3122A

U.S. Mail:
Total Compensation
100 Donhowe Bldg.
319 15th Avenue SE
Minneapolis, MN 55455-0103

Fax: 612-626-0808
Phone: 612-624-8647
Email: benefits@umn.edu