Request for Continuation of Coverage—COBRA

Office of Human Resources
University of Minnesota

Complete the following information and mail to the address shown on the *COBRA Continuation of Coverage* notice no later than 60 days after the loss of coverage. Be sure you show your correct 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 Individual Applying for Coverage (Please Print)

Name (Last, First, MI) | Employee ID No. or Social Security No. | Date of Birth

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

If the employee is not the individual applying for coverage, please complete:

Name of Employee:_____ Employee ID No:_____ Social Security No:_____

Reason for Continuation of Coverage (Check box and complete information requested)

- ❑ Employment termination/layoff/paid U of M layoff — Last day worked _____
- ❑ Change in employment status — Last day of 50% or greater work time _____
- ❑ Divorced spouse — Date of divorce _____
- ❑ Death of employee — Date of death _____
- ❑ Loss of eligibility — Date of ineligibility of dependent child _____

Continuation of Group Medical and Dental Coverage

❑ Yes ❑ No **I wish to continue my medical coverage**. Name of Plan _____

- ❑ Applicant Only
- ❑ Applicant and Children
- ❑ Applicant and Spouse with or without Children

❑ Yes ❑ No **I wish to continue my dental coverage**. Name of Plan _____

- ❑ Applicant Only
- ❑ Applicant and Children
- ❑ Applicant and Spouse with or without Children

Office Use Only

Effective Date

_____

U of M initials

_____

Date Submitted/ Entered

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

		Amount of Coverage
❑ Yes ❑ No	Basic Employee Life	$_____
❑ Yes ❑ No	Additional Employee Life	$_____
❑ Yes ❑ No	Spouse Life	$_____
❑ Yes ❑ No	Child Life	$ 10,000

Continuation of Health Care Flexible Spending Account – (Complete only if you currently have a Health Care Flexible Spending Account)

❑ Yes ❑ No I wish to continue my 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)

Name (Last, First, MI)	Date of Birth	Gender	Social Security No.
Spouse:			
Child:			
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 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 Employee Benefits 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:** _____

Please make a copy of this application for your records and send the original to:
Employee Benefits, University of Minnesota, 200 Donhowe, 319 15th Ave SE, Minneapolis, MN 55455-0103

Information and Privacy—There are laws to protect your privacy

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

B. Supplying Information – Your Rights

- **Minnesota Statute 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 Employee Benefits 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
- Prepare statistical reports and evaluative 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 is no charge for this service, but there is a small copy charge should you need copies.