Office of Human Resources
University of Minnesota
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Open Enrollment Change of Coverage
2023 Plan Year: COBRA/Former Employee

Applicant Information *(please print)*

Last Name | First Name | MI | Social Security Number

Current Home Address | City | State | Zip Code

Date of Birth *(MM/DD/YY)* | Phone number | Email address

Medical Plan

- ☐ Medica Elect/Essential (Twin Cities and Duluth Only)
  Primary Care Clinic Code required: _____
- ☐ Medica Choice National
- ☐ Medica HSA
- ☐ ACO-VantagePlus with Medica (Twin Cities Only)
- ☐ ACO-Park Nicollet First (Twin Cities Only)
- ☐ ACO-Ridgeview Community Network (Twin Cities Only)
- ☐ Medica Choice Regional (Greater Minnesota Only)
- ☐ ACO-Altru & You (Crookston Only)
- ☐ ACO-Essentia Choice Care (Northern Minnesota Only)
- ☐ ACO-Medica ChoiceHealth-Mayo (Rochester Only)

Note: You must live in the area served by the ACO you choose

Select Coverage Level:

☐ COBRA Applicant ☐ COBRA Applicant & children ☐ COBRA Applicant & Spouse with or without children ☐ I elect to waive coverage (no coverage)

Dental Plan

☐ Delta Dental PPO ☐ Delta Dental Premier

Select Coverage Level:

☐ COBRA Applicant ☐ COBRA Applicant & children ☐ COBRA Applicant & Spouse with or without children ☐ I elect to waive coverage (no coverage)

Persons to be Enrolled and Dependent Information

If enrolling a new dependent, former employee is responsible for full cost of that person's benefits.

Medical	Dental	Relationship	Last Name	First Name	Social Security No.	Gender (M/F)	Date of Birth (MM/DD/YY)	Primary Care Clinic Code*
☐	☐	Self:						
☐	☐	Spouse:						
☐	☐	Child – birth to age 26						
☐	☐	Child – birth to age 26						
☐	☐	Child – birth to age 26						

*A Primary Care Clinic code is required for enrollment in Medica Elect/Essential. Failure to add a correct number will result in an enrollment error.

Coordination of Benefits

Do you or your dependents have other health insurance? ☐ Yes ☐ No If yes, who is covered? ☐ Self ☐ Spouse ☐ Children

Company where coverage is obtained | Policy Number

Authorization *(Please read before signing)*

I am applying for a change in coverage in the University's medical and/or dental plan, subject to approval of my eligibility. I understand that coverage is continued at my expense. I verify that any dependents listed are eligible. I authorize the University to disclose the above information to the plan administrator(s) that I elected for use in processing my application. I further understand that failure to notify Total Compensation on a timely basis of loss of eligibility for any of my dependents or providing false information on this form may result in disciplinary action up to and including termination of benefits. I agree that, if either event occurs, the University may recover damages for losses and reasonable attorney's fees incurred to recover such damages. If I have enrolled in the ACO Plan, I acknowledge that Medica and the ACO network I have elected will share health record information to help coordinate care for my family and me. This authorization is valid until revoked by operation of law.

Applicant Signature | **Date**

Continue to back for more information

UPlan

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Medicare Information

If yes, name of person with Medicare A coverage _____ Effective Date _____

Medicare number (found on Medicare card) _____

Do you or any covered family members have Medicare Medical Coverage (Part B)? ☐ Yes ☐ No

If yes, name of person with Medicare B coverage _____ Effective Date _____

Medicare number (found on Medicare card) _____

Reason for Medicare coverage: (check one) ☐ Age ☐ Disability ☐ End stage renal disease

If more than one family member has Medicare parts A or B, please attach additional information

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 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
- 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.

OFFICE USE ONLY: Effective Date of Change: **January 1, 2023 COBRA Continuation**

U of M initials: _____ Date Submitted/Entered: _____

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 application for your records and return the original form by mail or fax.

Campus Mail: Office of Human Resources 100 DonhoweB Del Code 3122A

U.S. Mail: Office of Human Resources 100 Donhowe Bldg. 319 15th Avenue SE Minneapolis, MN 55455-0103

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