Student Health Benefits

UNIVERSITY OF MINNESOTA
Driven to Discover℠

COBRA—HealthPartners Benefits
2010-2011 Medical School Residents and Fellows
Enrollment, Change, and Payroll Deduction Form

Optional enrollment for resident/fellows in job codes 9554, 9555, 9556, 9559, 9568, 9569, 9582, 9583 who are completing residencies/ fellowships, and their dependents. At the end of your residency/fellowship, those enrolled in HealthPartners have the option to enroll in COBRA. **You will be enrolled in the same level of benefits as you had as a resident/fellow.** COBRA enrollment must be completed within 60 days of completion date. You may stay enrolled in COBRA for up to 18 months continuously. Those previously enrolled in the BCBS plan are also eligible.

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

B. Enrollment Information—please make plan selection and name all persons to be covered

Basic Option

___ Resident/Fellow Only	$300.70/month
___ Resident/Fellow and Spouse/SSDP	$918.00/month
___ Resident/Fellow and Child	$720.02/month
___ Resident/Fellow and Children	$1,046.11/month
___ Resident/Fellow and Family	$1,145.05/month

Basic Plus Option

___ Resident/Fellow Only	$346.39/month
___ Resident/Fellow and Spouse/SSDP	$1,081.10/month
___ Resident/Fellow and Child	$844.97/month
___ Resident/Fellow and Children	$1,234.00/month
___ Resident/Fellow and Family	$1,397.40/month

_X_ Resident/Fellow

___ Spouse/SSDP* _____
Name (Last, First, Middle Initial) *(Please Print)* | Date of Birth | Gender | Social Security Number

___ Child _____
Name (Last, First, Middle Initial) *(Please Print)* | Date of Birth | Gender | Social Security Number

___ Child _____
Name (Last, First, Middle Initial) *(Please Print)* | Date of Birth | Gender | Social Security Number

* Same-sex Domestic Partner

If more than two children, please use the back of this form.

C. Qualifying Event—please indicate reason for COBRA application

___ Completion of residency or fellowship ___ Early termination of residency or fellowship

D. Resident/Fellow Authorization

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 HealthPartners 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 | Date Signed

Please submit to: Office of Student Health Benefits, 410 Church Street S.E., N323, Minneapolis, MN 55455. Fax: (612) 626-5183 or 1-800-624-9881. Please keep a copy of this form for your records. For more information, visit the Office of Student Health Benefits website at www.shb.umn.edu.