Benefits Election

Return to:
University of Minnesota Employee Benefits 100 Donhowe
319 15th Ave SE
Minneapolis, MN 55455

Related Policy: : Non-Renewal Program for Academic Professional and Administrative Employees

Name:	Date of Birth:	Employee ID:
Spouse Name:	Date of Birth:	
Street Address:		
City:	State:	Zip:
Phone (with area code):	Last Day of Employment:	

I. MEDICAL & DENTAL BENEFITS (check one of the following options)

☐ I have less than three years of service, and I understand that I am eligible for COBRA continuation only.

☐ I have three or more years of service, and I wish to elect COBRA continuation for up to 18 months, foregoing any University contribution under this Layoff Severance Program.

☐ I have three or more years of service, and I wish to elect medical and dental benefits under the Layoff Severance Program. I understand that the University will contribute to the cost of my benefits based on my years of continuous service. I understand that the contribution will be based on my level of coverage (employee-only or tier of family coverage), work location, and permanent residence as of my last day of employment. I also understand that if the above contribution is for less than 18 months, I may continue coverage, payments would be payable to 121 Benefits / BRI for the balance of the 18 months at my own expense.

☐ I am age 65 or over:

Do you have or have you applied for Medicare? ☐ Yes ☐ No
If yes, please indicate: ☐ Part A ☐ Part B
Does your spouse have or have they applied for Medicare? ☐ Yes ☒ No
If yes, please indicate: ☐ Part A ☐ Part B

☐ I DO NOT wish to continue any medical and dental coverage.

II. Continuation of Group Life Insurance and Health Care Flexible Spending Account

Note: This form is used to enroll in medical and dental only. In order to reinstate group life insurance and/or a Health Care Flexible Spending Account, follow instructions provided in the COBRA notice, which will be issued via U.S. mail from 121 Benefits/BRI. If you'd like to continue University dental and medical benefits, do not elect those benefits on the COBRA notice.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____