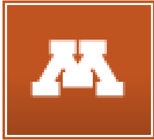

APPENDIX

Benefits Election

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

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Employee Name ______________________ Date of Birth ______________
Employee ID Number ______________________
Spouse Name ______________________ Date of Birth ______________
Home Address ______________________
(Street) (City) (State) (Zip)
Home Phone No. ______________________ 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. *(Contact your department for application.)*
- ☐ 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 Non-Renewal Program. *(Contact department for application)*
- ☐ I have three or more years of service, and I wish to elect medical and dental benefits under the Non-Renewal 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 for the balance of the 18 months at my own expense.
- ☐ I am age 65 or over: ☐ Yes ☐ No Do you have or have you applied for Medicare?
  If yes, please indicate: ☐ Part A ☐ Part B
  ☐ Yes ☐ No Does your spouse have or has your spouse applied for Medicare?
  If yes, please indicate: ☐ Part A ☐ Part B
- ☐ I DO NOT wish to continue any medical and dental coverage.

II. LIFE INSURANCE *(check one of the following options)*

- ☐ I wish to elect COBRA continuation for my life insurance coverage.
- ☐ I DO NOT wish to continue any life insurance coverage.

III. HEALTH CARE FLEXIBLE SPENDING ACCOUNT *(check if applicable)*

- ☐ In order that I may be reimbursed for eligible expenses incurred after termination of employment, I wish to elect continuation of my health care flexible spending account on an after-tax basis in monthly installments.
  Expenses can only be reimbursed if incurred in a period for which the contribution has been paid.
- ☐ I wish to continue my health care flexible spending account pre-funded by payroll deduction.

Employee Signature ______________________ Date ______________

Spouse Signature ______________________ Date ______________

RETURN TO: University of Minnesota, Employee Benefits, 100 Donhowe, 319 15th Ave SE, Minneapolis, MN 55455-0103