UPlan

Office of Human Resources
University of Minnesota
Driven to Discover®

Request for Continuation of Coverage

Applicant Information ***(please print)***

Last Name | First Name | MI | Social Security Number or Emp ID | Date of Birth *(MM/DD/YY)*

Current Home Address | City | State | Zip Code | Phone Number (required)

Name of Spouse (Last, First, MI) | Social Security Number | Date of Birth *(MM/DD/YY)*

Reason for Electing Coverage **Date of event:**_____ **Last Day Worked:**_____

☐ Retirement ☐ Turning Age 65 ☐ End of Agreement (Phased or Severance) ☐ Disability

Continuation of Medical Coverage

*Check the boxes below for coverage you would like to continue through the University.

Active Employee Plans ☐ **Retiree/Disabled Participant under 65** ☐ **Spouse under 65** ☐ **Dependents**

☐ Medica Elect/Essential (Twin Cities and Duluth Only)

Primary clinic code is 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 (Duluth and Northern Minnesota Only)

☐ ACO-Medica CompleteHealth-Mayo (Rochester Only)

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

Medicare Supplement Plans

	Retiree/Disabled Participant on Medicare	Spouse on Medicare
BCBS – Plan 1	☐	☐
BCBS – Plan 2	☐	☐
HealthPartners – Plan 1	☐	☐
HealthPartners – Plan 2	☐	☐
Medica – Plan 1	☐	☐
Medica – Plan 2	☐	☐
UCare – Plan 1	☐	☐
UCare – Plan 2	☐	☐

Continuation of Dental Coverage

☐ I wish to continue my current group dental coverage

I wish to change my dental plan to: ☐ Delta Dental PPO ☐ Delta Dental Premier

☐ Retiree Only
☐ Retiree and Children
☐ Retiree and Spouse with or without Children

Enrollees for Medical & Dental Plans

Medical	Dental	Name (Last, First, MI)	Date of Birth	Social Security Number
☐	☐	Self		
☐	☐	Spouse		
☐	☐	Dependent		

Continue to back to complete application

Office of Human Resources
University of Minnesota
Driven to Discover®

Continuation of Group Life Insurance *(Up to 18 months – Applies only for newly retired employees)*

☐ Basic Employee Life	☐ Spouse Life
☐ Additional Employee Life	☐ Child Life

Continuation of Health Care Flexible Spending Account

☐ I wish to continue my current Health Care Flexible Spending Account on an after-tax basis for the remainder of the calendar year.

Billing

You will be billed directly by the plans for medical and dental coverage and by the COBRA Administrator for life insurance and the Health Care Flexible Spending Account.

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 Total Compensation 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.

Authorization *(Please read before signing)*

I am applying for a change in coverage in the University of Minnesota UPlan, 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.

Employee Signature: _____ **Date:** _____

Spouse Signature: _____ **Date:** _____

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

Campus Mail:
Total Compensation
100 DonhoweB
Del Code 3122A

U.S. Mail:
Total Compensation
100 Donhowe Bldg.
319 15th Avenue SE
Minneapolis, MN 55455-0103

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