COBRA DENTAL BENEFITS

ANNUAL ENROLLMENT FORM 2024

Return to UMR by December 6, 2023.

UMR COBRA Administration
PO Box 1206
Wausau WI 54402-1206

Fax: 877-291-3241

Email: mycobra@umr.com

Name:	Date of Birth:	Sex:
Home Address:	Home Phone:	
City/State/Zip:	Work Phone:	

Complete the information below for your spouse and/or dependents. Indicate whether you are adding or deleting a spouse and/or dependent by checking the appropriate boxes under Dental. If you have additional dependents you would like to cover, write them on a separate page and submit along with this form.

SPOUSE/DEPENDANT INFORMATION

Name	SSN	Relationship	Sex	DOB	Dental	
					Add	Delete
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Note: Handicapped Child Prior to Age 26: ☐ Yes (Please note with an asterisk (*) next to the name above)

DENTAL

Your monthly cost for dental coverage depends on the coverage category you choose.

OPTION	COVERAGE CATEGORY	COST OF COVERAGE
☐ No Coverage	☐ Employee Only	$42.84
☐ Elect Dental Plan	☐ Employee Plus Spouse	$81.60
☐ Change Dependents	☐ Employee Plus Child	$87.72
☐ Terminate Coverage	☐ Employee Plus Children	$87.72
	☐ Family	$124.44

OTHER GROUP DENTAL COVERAGE

As a COBRA participant in the Methodist Health System Employee Dental Care Plan, your COBRA coverage will end if other dental coverage becomes effective after you elected COBRA coverage.

Do you have other dental coverage? ☐ Yes ☐ No Date other coverage began _____

Do your spouse/dependents who are COBRA participants have other dental coverage?

☐ Yes ☐ No Date other coverage began _____

BENEFITS ENROLLMENT AUTHORIZATION

I authorize the change to my COBRA dental coverage as shown on the Enrollment Form.

Participant Signature _____ Date _____