COBRA HEALTH 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 Health. 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	Health	
					Add	Delete
					☐	☐
					☐	☐
					☐	☐
					☐	☐

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

Note: There are two options for Health: $1,200 Deductible PPO and High Deductible Health Plan. Your monthly cost for health coverage depends on the coverage category you choose.

HEALTH – PPO

OPTION	COVERAGE CATEGORY	COST OF COVERAGE
☐ No Coverage	☐ Employee Only	$ 781.32
☐ Elect Health Plan	☐ Employee Plus Spouse	$1,676.88
☐ Change Dependents	☐ Employee Plus Child	$1,489.20
☐ Terminate Coverage	☐ Employee Plus Children	$1,489.20
	☐ Family	$2,537.76

HEALTH – HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

OPTION	COVERAGE CATEGORY	COST OF COVERAGE
☐ No Coverage	☐ Employee Only	$ 732.36
☐ Elect HDHP Plan	☐ Employee Plus Spouse	$1,574.88
☐ Change Dependents	☐ Employee Plus Child	$1,395.36
☐ Terminate Coverage	☐ Employee Plus Children	$1,395.36
	☐ Family	$2,397.00

OTHER GROUP HEALTH COVERAGE

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

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

Do your spouse/dependents who are COBRA participants have other group health coverage?
☐ Yes ☐ No Date other coverage began _____

BENEFITS ENROLLMENT AUTHORIZATION

I authorize the change to my COBRA health coverage as shown on the Enrollment Form. I understand that, for the Health Care Plan, I cannot make a change to another option during the Plan Year (January 1 – December 31).

Participant Signature _____ Date _____

Send Completed form to:

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