COBRA VISION 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	Vision	
					Add	Delete
					☐	☐
					☐	☐
					☐	☐
					☐	☐

VISION

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

OPTION	COVERAGE CATEGORY	COST OF COVERAGE
☐ No Coverage	☐ Employee Only	$ 10.10
☐ Elect Vision Plan	☐ Employee Plus One	$ 19.18
☐ Change Dependents	☐ Family	$ 28.18
☐ Terminate Coverage		

OTHER GROUP DENTAL COVERAGE

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

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

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

☐ Yes ☐ No Date other coverage began _____

BENEFITS ENROLLMENT AUTHORIZATION

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

Participant Signature _____ Date _____