University Health

2025 COBRA Benefit Election

Last Name	First Name	M.I.	Social Security Number		Date of Birth
Street Address	**City**		**State**	**Zip code**	**Phone Number:**

Medical Enrollment:

❑ **University Family Care Plan**	❑ Participant Only ❑ Participant & Spouse/Domestic Partner	❑ Participant & Child(ren) ❑ Participant & Family	❑ Decline

Dental Enrollment: (Choose One from the 4 Plans Listed)

Humana DHMO	Humana DPO	Coverage Level	
❑ DHMO	❑ Bronze Plan ❑ Silver Plan ❑ Gold Plan	❑ Participant Only ❑ Participant & Spouse/Domestic Partner ❑ Participant & Child(ren) ❑ Participant & Family	❑ Decline

Vision Enrollment:

❑ **EyeMed**	❑ Participant Only ❑ Participant & Spouse/Domestic Partner	❑ Participant & Child(ren) ❑ Participant & Family	❑ Decline

List self and all eligible dependents information below you wish to cover (please print clearly):

Name	Relationship	DOB	Gender (M/F)	Humana HS405 DHMO Provider:	Social Security Number	Medical (Y/N)	Dental (Y/N)	Vision (Y/N)
	Self							
	Spouse							
	Child							
	Child							
	Child							

I certify that I am, and each of my enrolled dependents is, eligible to participate in plans elected for us on this form, as eligibility is defined in each plan. **I understand that my benefit elections cannot be changed before the next open enrollment unless there is a qualifying event. Changes must be requested within 31 days from the date of the event.**

AUTHORIZATION: I hereby authorize my licensed physician, hospital, pharmacy, clinic, health care facility, insurance company, employer, or organization to release to University Health or its agents any information regarding me or my enrolled family members' medical history, treatment, and/or disability that is reasonably necessary for the purpose of utilization review, coordination of benefits, or payment of a claim. The authorization shall cease to be effective at such time when my coverage under the plan terminates. In the event that I have any outstanding claims at time of termination, the authorization will continue to apply until all the claims have been settled. I hereby attest that the statements made by me are true, and I understand that any material misstatements may be used to contest the validity of my benefits.

Participant Signature:		Date:	
Office Use Only	Effective Date:	Date Entered:	Initials:

White – Human Resources Yellow – Participant