UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

UT FLEX COBRA Application

HEALTH CARE REIMBURSEMENT ACCOUNTS FOR PLAN YEAR 2025-2026

Please type or print clearly in black or blue ink. Be sure to complete the entire form, including the signature and date. Detailed instructions are listed on page 2.

A APPLICANT INFORMATION

Name (Last, First, Middle)			**HR STAFF USE ONLY** Purpose of this application: To apply for continuation of a UT FLEX HRCA after a member has lost eligibility.	
Employee ID/Benefits ID (BID)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	UT Institution	
Street Address			Benefits Representative	Date of Formal Notice
City	State	Zip Code	Phone Number	Date COBRA Election Period Ends
Phone Number	Email Address		Email Address	

B COBRA ELIGIBILITY

Your monthly UT FLEX COBRA premium includes an administration fee and therefore will total 102% of the monthly deduction amount paid prior to your COBRA qualifying event. COBRA premium payments should be submitted to the UT FLEX administrator at the address listed on the back of this form. Your COBRA coverage may continue with the same annual election amount through the end of the plan year for which your UT FLEX coverage was in effect. The UT FLEX Debit Card is not available for COBRA participants. (Please note: UT FLEX Dependent Day Care Reimbursement Accounts are not eligible for continuation through COBRA.)

DATE COVERAGE WAS TERMINATED

DATE COBRA COVERAGE BEGINS

C MONTHLY PREMIUM

To determine your monthly UT FLEX COBRA premium, please use the formula below:

Previous Monthly UT FLEX Payroll Deduction		Monthly UT FLEX COBRA Premium
$	**x 1.02 =**	$

This signed and dated Application must be mailed to the UT FLEX administrator within 60 days of the date your active coverage was terminated. If you fail to meet this deadline, you will not be eligible for COBRA continuation of your UT FLEX Health Care Reimbursement Account.

D ELECTION AND CERTIFICATION

I have received and read the election notice. I elect to continue UT FLEX coverage under the provisions of COBRA.

I understand that the "use-it-or-lose-it" rule outlined in the UT FLEX plan booklet will continue to apply and any unused funds will be forfeited after the claims filing deadline for this plan year.

I understand that I am eligible to continue my UT FLEX account through the end of the plan year in which I was last actively employed with a University of Texas institution and established the account.

I understand that my monthly UT FLEX COBRA premium is paid with after-tax dollars.

State Government Privacy Policy

With few exceptions, you are entitled to request and to receive and review under Sections 552.021 and 552.023 of the Texas Government Code (the Texas Public Information Act), information that UT System Administration or another UT System institution collects and retains about you. Under Section 559.004, you are entitled to have incorrect information that is retained about you corrected. You can obtain information about how to request access to such information at: **www.utsystem.edu/ogc/openrecords/access.htm**.

Notice About Social Security Numbers (SSNs)

Federal law requires the University of Texas System to report income information and the SSN for all employees to whom compensation is paid. Employee's SSNs are also maintained and used for payroll and benefits and verification purposes as required and permitted by state and federal law. Non-employee SSNs are requested for use and disclosure for benefits and verification purposes as permitted by state and federal law.

Applicant Signature	**Signature Date**

INSTRUCTIONS FOR COMPLETING AND FILING THIS APPLICATION

Please complete this form entirely and do not send to your local Benefits Office. See filing instructions below.

COBRA (Consolidated Omnibus Budget Reconciliation Act) is the federal law that provides the right to continue healthcare coverage when participants no longer qualify for coverage through their employer's group health plan. Please refer to the UT System COBRA Continuation Coverage Notice.

HOW TO FILE THIS FORM

After application has been completed, a copy must be sent to the UT FLEX administrator along with any additional attachments. A check for the initial payment may also be sent along with this application. An incomplete application may delay processing.

APPLICATION DEADLINE

A copy of this application must be mailed to the UT FLEX administrator and postmarked within 60 days after the date that UT Flex participation was terminated (last day of the month in which the qualifying event occurred) or the date member received the formal notice from the UT Institution, whichever is later.

PAYMENTS

Payment must be submitted within 45 days of the election date, which is the postmark date when this application was mailed to the UT FLEX administrator. The initial payment should cover the number of full months from the date the benefits coverage was terminated. After the initial payment, the same payment(s) must be submitted each month unless a contribution change notice is issued. If a monthly payment is not made within 30 days of its due date, eligibility will cease on the last day for which a contribution was paid and cannot be reinstated.

Checks and money orders are payable to Inspira Financial.

If additional help is needed with this application, members may contact their local benefits office.

HOW TO COMPLETE THIS FORM

A. APPLICANT INFORMATION

All fields in this section are required. The Benefits ID (BID) is a unique identifier that has been assigned to every UT Benefits participant by The Office of Employee Benefits at The University of Texas System.

How to find your BID

Your BID is on your Delta Dental card or UT SELECT Prescription card. It is also listed on your UT SELECT Medical card after "UTS0". If you have trouble finding your BID, you can contact your local Benefits Office.

B. COBRA ELIGIBILITY

Date Coverage was Terminated is the last day of the month the qualifying event occurred. **Date COBRA Coverage Begins** is the first day of the month following benefits termination.

C. MONTHLY PREMIUM

Enter the monthly premium amount that was being deducted from your paycheck at the time your benefits terminated. If you are completing this form electronically, the UT FLEX COBRA premium amount will be automatically calculated at 102% of the previous monthly premium. If you are completing this form manually, multiply the previous monthly premium amount times 1.02 to obtain the UT FLEX COBRA premium amount.

D. ELECTION & CERTIFICATION

Please read through the items to be acknowledged. The applicant must sign and date this form.

MAIL SIGNED & COMPLETED APPLICATION, ALONG WITH INITIAL PAYMENT, TO THE UT FLEX ADMINISTRATOR:

Inspira Financial - COBRA
P.O. Box 8396
Omaha, NE 68108-8396

P: (844) 887-3539 | F: (844) 306-8147 | questions@inspirafinancial.com | www.myutflex.com