

Request To Elect Dental COBRA



EMPLOYER SECTION

NOTE: The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to notify qualified individuals in writing of the type of coverage subject to COBRA, the monthly premium to continue coverage, the time frame in which to elect COBRA continuation, the time and manner in which payments must be made, the address of the employer to remit payment and conversion option rights.

The employer section must be completed by you, the employer, and mailed to the qualified individual within **14 days** from the latter of: A) the date coverage terminated due to a qualifying event or; B) the date you are notified by the individual of a qualifying event.

The qualified individual must complete the reverse side within **60 days** from the latter of: A) the date coverage terminated due to a qualifying event; or B) the date individual is notified of the right to continue coverage. This form must be completed by the qualified individual and returned to you whether or not continuation of coverage is elected. You must then forward the completed form to Fortis Benefits Insurance Company, Customer Relations, PO Box 2939, Clinton, IA 52733.

Group name _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Employee name _____

Date coverage terminated _____ Date employer was notified of qualifying event _____

Date qualified individual was notified of COBRA rights _____

Qualifying Events *(Please check appropriate box.)*

- Employee terminated employment because of voluntary termination, unapproved leave of absence, lay-off or was dismissed for reasons other than gross misconduct: 18 months
- Employee's hours were reduced: 18 months
- Death of the covered employee: 36 months
- Divorce or legal separation of the covered employee from spouse: 36 months
- The covered dependent child ceases to be an eligible dependent under the terms of the employer's dental plan: 36 months
- The occurrence of a second qualifying event. Explain. _____

- Extension of the 18-month COBRA continuation of coverage period up to a maximum of 29 months due to disability. *(Certificate of entitlement must be submitted as proof of disability.)*

COBRA benefits will be terminated if premiums are not paid in a timely manner or if other group dental coverages are obtained.

Employer's signature _____ Date _____

QUALIFIED INDIVIDUAL SECTION

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), allows coverage for employees and/or dependents who are eligible to continue his/her insurance for a specified period of time if coverage is lost or terminated under the employer's dental plan due to a qualifying event.

If you wish to continue your dental plan, at your own expense, please complete this form. This form must be completed and returned to the employer within **60 days** from the latter of: A) the date coverage is terminated due to a qualifying event or; B) the date the individual is notified by the employer of his/her right to continue coverage. Initial premium payment must be made to the employer within **45 days** after coverage has been elected. COBRA continuation coverage will begin retroactively to the date coverage terminated due to the qualifying event. **This form must also be completed and returned to the employer if continuation of coverage is not elected.**

If you or your dependents obtain or are already covered under another group dental plan (*that does not exclude or limit coverage for pre-existing conditions*) after the date continuation of coverage has been elected, then COBRA continuation will terminate as of the effective date of the other group dental plan.

Failure to respond within the prescribed time period will be considered a refusal to continue coverage under the employer's group plan.

Please print.

Group name _____ Policy no. _____
 Participation no. _____ Account no. _____ Certificate no. _____
 Employee name _____
 Employee's address—Street _____ City _____ State _____ Zip _____

List all qualified individuals to be covered under the continuation and check the coverages to be continued. (*Any qualified individuals that are not listed will not be insured for continuation of coverage.*) Only those coverages that were in effect immediately prior to the date coverage terminated, can be continued. Use a separate sheet of paper if additional space is needed; sign and attach extra copies.

Qualified Individuals	Social Security No.	Date of Birth	Dental
Employee's name			
Spouse's name			
Dependent's name			
Dependent's name			

Are you or your dependents covered under another group dental plan? Yes No
 If "Yes," name of insurance company _____ Effective date _____

IMPORTANT! PLEASE SIGN

- I am electing to continue dental coverage as indicated above for those persons named. I understand that it is my obligation to pay all premiums when due in order to secure and maintain continuation of coverage.
 I also agree to notify the employer if I or my dependents become covered under another group dental plan.
- I am waiving my rights to continue all dental coverage for myself and/or my eligible dependents and do NOT wish to elect continuation of coverage.
 If all coverage is being waived for employee and/or dependents, the employee and each adult (*18 or over*) dependent MUST sign the form.

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