**DENTAL OR VISION**

**FEDERAL COBRA ELECTION FORM**

Date:

To:

(Name of Employee or Qualified Beneficiary)

From:

(Name of Employer Group)

RE: Right to Continuation Coverage

This is to advise you that you and/or your covered family members have a right to continuation coverage under your employer’s Dental/and or Vision Plan. A federal law commonly referred to as COBRA allows you to extend this coverage at your own expense for a specified period of time. Each person covered on the day your coverage is terminated can elect continuation coverage independently. A child born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage also has a right to continuation coverage.

Under the law, you have 60 days from the date you would lose coverage because of a "qualifying event" or from the date you receive this notice, whichever is later, to inform your employer that you want COBRA. Your dental and/or vision insurance will terminate as a result of the “qualifying event” indicated below. It will be retroactively reinstated once coverage has been selected and paid for. Coverage will be identical to the coverage provided under the Plan to similarly situated employees.

You and/or your covered dependents are entitled to continuation coverage for the specified time because of the following qualifying event:

**18 Months 36 Months**

\_\_\_ Termination of employment \_\_\_ Death of Employee

*(for reasons other than gross misconduct)* \_\_\_ Divorce/Separation

\_\_\_ Loss of coverage due to reduction in work hours \_\_\_ Ineligible dependent child

\_\_\_ Medicare-ineligible spouse/child

As a result of the "qualifying event" above, your group coverage terminates .

Continuation coverage, if elected, will begin on and end on .

Your COBRA coverage must match your current election or be reduced to Employee only.

Please select your coverage options below. Current monthly premiums are listed. Dependents going on COBRA would choose Employee coverage.

**Dental Vision**

\_\_\_Employee $\_\_\_\_\_\_\_\_ \_\_\_Employee $\_\_\_\_\_\_\_\_

\_\_\_Employee and spouse $\_\_\_\_\_\_\_\_ \_\_\_Employee and spouse $\_\_\_\_\_\_\_\_

\_\_\_Employee and children $\_\_\_\_\_\_\_\_ \_\_\_Employee and children $\_\_\_\_\_\_\_\_

\_\_\_Employee and family $\_\_\_\_\_\_\_\_ \_\_\_Employee and family $\_\_\_\_\_\_\_\_

**COBRA PAYMENT NOTICE**

• **You must elect continuation of coverage by completing this form within 60 days of the date you were notified or the qualifying event date, whichever is later.**

• Premiums are due the first of each month. **Premiums not received within 30 days of the due date will be considered delinquent. Failure to pay premiums timely will result in cancellation.**

• **NO BILLING NOTICE WILL BE SENT**

• You have 45 days from the date you elect continuation coverage to make the first payment which includes all arrears fees.

* **DO NOT WAIT TO RECEIVE A BILLING NOTICE BEFORE MAKING THIS PAYMENT.** If the initial payment is not received within 45 days of the election date, continuation coverage will not be provided.

Certain disabled qualified beneficiaries can have an 11 month extension from 18 months to 29 months. To qualify, the individual must be disabled at the time of the termination of employment or reduction of employment hours or become disabled at any time during the first 60 days of COBRA continuation coverage. The disability must be determined under the Social Security Act. Notice of the disability determination must be given to your employer within 60 days of the date of disability determination and within the 18 month period after the covered employee's qualifying event for continuation coverage. Employer must be notified within 30 days of any final determination that the individual is no longer disabled.

**TO BE COMPLETED BY EMPLOYEE/QUALIFIED BENEFICIARY**

I acknowledge receipt of the above notice of right to continuation coverage. For myself and family members if any, I elect:

\_\_\_ Not to have COBRA continuation coverage.

\_\_\_ To have COBRA continuation coverage and understand that I am responsible for payment of the entire premium amount.

I understand that continuation coverage ceases at the expiration of the allowed number of months.

It can end earlier in case of any of the following:

1. The employer no longer provides group health coverage to any of its employees;

2. The premium for continuation coverage is not paid on time;

3. I become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition I or my covered dependents may have;

4. I become entitled to Medicare;

5. I extend coverage for up to 29 months due to disability and there has been a final determination that I am no longer disabled.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Employee/Qualified Beneficiary Address

**This form should be completed and sent to:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Checks should be made payable to: