

COBRA Administration 3 tier rates form

Wolfpack Insurance Services

Delta Dental COBRA form, for those persons terminating benefits.

Employer, please complete the following information:

Date of issuing notice: _____

Date Employer Coverage Ends: _____

COBRA Effective Date: _____

COBRA APPLICANT INFORMATION: Invoices will be sent to the indicated address

Electing COBRA ?		Last Name	First Name	SS#	Birth Date	Gender
<input type="checkbox"/>	Applicant					
<input type="checkbox"/>	Spouse					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					
<input type="checkbox"/>	Child					

Address _____ Phone Number: _____

City _____ State _____ Zip _____

Reason establishing COBRA eligibility.		Date of qualifying event _____
18 Months Coverage: <input type="checkbox"/> Reduction of work hours <input type="checkbox"/> Termination of Employment	29 Months Coverage: <input type="checkbox"/> Social Security Disabled	36 Months Coverage: <input type="checkbox"/> Legal Separation or Divorce <input type="checkbox"/> Dependent Ceasing to be eligible <input type="checkbox"/> Death of Subscriber Please give primary members information Name _____ SS# _____

You must complete this form and return it to Wolfpack Insurance Services, Inc within 60 days of the qualifying event date or the date of issuing notice, whichever is later. In order to continue your coverage, you will be required to make a monthly premium payment. We will send you an invoice. If you do not return this form within the above time limit, it is assumed you have elected not to continue coverage. Each individual has an independent right to elect COBRA coverage.

BREAKDOWN OF CHARGES		
Dental	Member: _____	Member and one dependent: _____ Member and Two or More: _____

If elected, the continued coverage will end on the earliest of the following:

- The date the COBRA eligibility ends as indicated under the reason for establishing COBRA eligibility;
- The date the employer ceases to provide any group dental plan to any employee;
- The date the employee or dependent fails to make an requested premium payment when due;
- The date the employee or dependent becomes a covered employee under any other group plan or eligible for Medicare.

I do **NOT** wish to continue any coverage under the plan.

I elect **TO** continue coverage and agree to the conditions and requirements as outlined. Please continue coverage for members indicated as electing COBRA.

Signature of Applicant or Spouse or legal guardian, if electing on behalf of minor child.

_____ Date _____

Company Information/ Certified by Employer

Group Name: _____ Client ID: _____ - _____ # of active employees: _____

Name of Individual certifying this notice: _____ Title: _____

Signature: _____ Date: _____

This notice is intended to inform you of your rights and obligations under the continuation coverage provisions of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). You (and your spouse if applicable) should take the time to read this notice carefully.

You have the right to choose continuation of coverage if you lose your group health coverage (dental and/or vision in this case) because of the reason indicated on page one.

If you are the spouse or dependent of the covered person and have dependent coverage, you have the right to choose continuation of coverage for your self if you lose coverage for any of the following reasons: (1) the death of your spouse; (2) the termination of your spouses employment or reduction of your spouse's hours of employment; (3) the employee's divorce or legal separation; (4) the employee becomes entitled to Medicare.

In the case of a covered dependent child of the covered employee, additionally he or she has the right to continuation of coverage if the group coverage is lost when the dependent child ceases to be a 'dependent child' under the covered person.

Under the law, the employee or family member has the responsibility to inform Wolfpack Insurance Services, Inc, the Plan Administrator, of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the employee's death, termination, and reduction in hours or Medicare entitlement. When Wolfpack Insurance Services, Inc is notified that one of these events has occurred, we will notify you that you have the right to choose continuation of coverage. Under the law you have at least 60 days, from the date you would lose coverage, to inform Wolfpack Insurance Services, Inc that you want continuation of coverage. If you do not choose continuation of coverage in a timely manner your dental insurance coverage will end.

If you choose continuation coverage, the continued coverage under the plan is to be identical to similarly situation employees or family members as of the time coverage is being provided. The required continuation of coverage period is shown on the front of this notice with the indicated reason. The 18 month period may be extended for covered individuals to 36 months if other events such as death, divorce, legal separation or Medicare entitlement occur during that 18 month period.

The 18 months may be extended to 29 months if a qualified person is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11 month extension is available to all individuals who are qualified persons due to a termination or reduction in hours of employment. To benefit from this extension a qualified person must notify Wolfpack Insurance Services, Inc of that determination within 60 days and before the end of the original 18-month period. The covered individual must also notify Wolfpack Insurance Services, Inc within 30 days of any final determination that he/she is no longer disabled.

A child who is born or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to qualify for coverage, in accordance with plan terms, with proper notification to Wolfpack Insurance Services, Inc of the birth or adoption.

The law also provides that continuation of coverage may be cut short for any of the following five reasons: (1) employer no longer provides group dental coverage to any of its employees; (2) premium is not paid on time; (3) the qualified person becomes covered – after the date he/she elects COBRA coverage – under another group dental and/or vision plan that does not contain any exclusion or limitation with respect to any pre-existing condition; (4) the qualified person becomes entitles to Medicare after the date he/she elects COBRA coverage; (5) the qualified person extends coverage for up to 29 months due to disability and a final determination finds the individual no longer disabled.

You do not have to show that you are insurable to choose continuation of coverage. However, continuation of coverage under COBRA is provided subject to your eligibility of coverage. Wolfpack Insurance Services, Inc reserves the right to terminate coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all of part of the premium for your continuation of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

To activate your continuation of coverage, complete the form and return with your check for the premium due within 60 days of your termination date. Invoices are mailed on or around the 10th of the month and due on the 25th prior to the month of coverage.

If you have any questions, please feel free to contact us (800-296-0192). Also if you have changed marital status, or you (or your spouse), have changed addresses, please notify us immediately.