



COBRA ELECTION FORM

You and your dependents, if they were previously covered, have the right to continue dental coverage as provided by your former employer.

If you elect to continue coverage, the benefits will be available until:

- a) The expiration of 18 or 36 months following the date coverage ceases (see exception below).
 - b) You are or become covered under another dental plan.
 - c) You fail to pay the monthly premium within 30 days of the due date.
 - d) Your former employer’s PMI plan is no longer in force.
1. You have 60 days from the date of this notice or from the date your previous coverage terminated – whichever is later – to notify us of your election. Please complete the information on the reverse side of this page and return it to the address indicated.
 2. To begin coverage, you must make your first payment within 45 days of signing and returning this form. Your first payment may include all monthly premiums due or the first month of your coverage only.
 3. Your next payment is due 30 days after the first payment; it **MUST** include all remaining monthly premiums to bring your account current.
 4. Subsequent monthly payments are due on the first of each month. Any payment not received within 30 days of the due date will cause your coverage to terminate.

EXCEPTION

If you are disabled before or within the first 60 days after you become eligible for this continuation benefit and remain disabled for the term of COBRA, you will be able to extend your COBRA benefit up to an additional 11 months with premiums to be determined. You must notify us within 60 days of notification by the SSA of your disability status and within your original continuation period.

NOTE: If you wish to elect COBRA, please complete the attached COBRA Election Form and return it to Wolfpack Insurance Services, Inc. at the address provided below. All inquiries should also be directed to Wolfpack Insurance.

***Wolfpack Insurance Services
P.O. Box 833
Belmont, CA. 94002
(800) 296-0192***

Headquarters Office:

P.O. Box 7736, San Francisco, CA. 94120

100 First Street, San Francisco, CA. 94105, (415) 972-8300

Offices In:

Sacramento, Cerritos, San Diego, Fresno

DentalandVisionIns.com **Wolfpack Insurance Services**

Delta Dental COBRA form*, for those persons terminating benefits

Employer please complete the following information:

Date of issuing notice: _____

COBRA Effective Date: _____

PERSONS ELIGIBLE FOR CONTINUED COVERAGE:

EMPLOYEE INFORMATION: Invoices will be sent directly to the employees indicated address			
Employee First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Spouse First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Child First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Child First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Child First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Child First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Child First Name _____	Last _____	SS# _____	Birth Date ____/____/____
Address _____			
City _____ State _____ Zip _____			
Phone Number: _____			

Under Federal and State Law, if your dental benefits end due to a “qualifying event”, you may elect to continue coverage under the plan. A “qualifying event” is any of the following:

- For an employee, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the employee ineligible for coverage.
Last day worked _____.
- Death of the employee, date _____ or,
- Divorce or legal separation, date _____ or,
- For a spouse and eligible dependents, loss of coverage due to the employee becoming eligible for Medicare, date _____ or,
- For dependent child, ceasing to qualify as a dependent under the plan, date _____.

In order to continue your coverage, you will be required to make a monthly premium payment. If you wish to continue this coverage you must return this form and pay the required premium to Wolfpack Insurance Services within 60 days of the qualifying event or receipt of this notice, whichever is later. Subsequent premiums must be paid by the twenty-fifth (25) of the month prior to coverage month. If you do not return this form within the above time limit, it is assumed you have elected not to continue coverage under the group plan.

COBRA is not eligible if coverage is in-force under another plan that does not exclude pre-existing conditions.

BREAKDOWN OF CHARGES:			
	EMPLOYEE	EMP + One	EMP + Two or more
Dental	_____	_____	_____

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

- 18 months after the date of termination of employment or reduction of hours;

- 36 months after the date of any other qualifying event;
- 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:

Myself only

Myself and dependents

Dependents only

List all people continuing below:
Name:

Signature of employee or continuing individual:

_____ Date _____

Certified by Employer:

Company Information:

Name of Individual

Group Name

Title

Delta Group Number

Signature: _____

Date: _____

MAIL COMPLETED COBRA ENROLLMENT FORM(S) TO:

Wolfpack Insurance Services, Inc.
P.O. BOX 833
Belmont CA, 94002
PHONE (800) 296-0192
FAX (650) 591-4022