

COBRA NOTICE/ELECTION FORM
DELTA DENTAL PLAN

This notice is to advise you that your dental coverage with Delta Dental has been terminated. You have the option to continue your benefits under the group plan through federal legislation called COBRA.

Any person covered under the group plan as of the Qualification Date is entitled to a separate election of continuation coverage. All coverage must begin on the day following the termination date of dental coverage as shown on the attached COBRA election form. **FEDERAL LEGISLATION PROHIBITS ANY LAPSE IN COVERAGE UNDER COBRA, AND ALL PREMIUMS MUST BE PAID RETROACTIVELY TO THE QUALIFICATION DATE.**

Election of COBRA coverage must be made within 60 days from the date of termination of your coverage, or date of this notice, whichever is later. All elections made will be retroactive to the qualifying event date. THE FULL COST OF THIS CONTINUED COVERAGE, PLUS AN ADDITIONAL 2% PLAN ADMINISTRATIVE FEE MUST BE PAID BY YOU OR YOUR DEPENDENT, AS APPLICABLE.

CONTINUATION PERIOD

The period for which benefits may be continued will depend on the type of qualifying event that occurs.

The maximum COBRA continuation period is 18 months for employees and their dependents for the following "qualifying events":

- Termination of employment other than gross misconduct;
- Reduction in hours/Leave of Absence; OR
- Layoff.

The maximum COBRA continuation period is 36 months for dependents for the following "qualifying events":

- Employee's death;
- Divorce or legal separation;
- Loss of dependent status (e.g., turns age 23, marries); or
- Termination of domestic partner relationship.

EXCEPTIONS

Disability Extension - An individual who is disabled at any time within the first 60 days of COBRA continuation coverage, and is determined to be disabled under Title II (OASDI) of XVII of the Social Security Act is entitled to continue coverage for an additional 11 months (29 months total). In order to receive the 11 month extension, a copy of the disability certification must be provided to the carrier within 60 days from the date of issue and before the original 18 month continuation period ends. A disability extension may be elected independently for each qualified beneficiary (not just the covered employee.) If the disabled individual is part of the

family unit that elects the disability extension, the premium will be 150%. Otherwise, the premium rate will be 102%. The 11 month extension may be terminated if a final social security determination is made stating the individual is no longer disabled.

Multiple Qualifying Events - If a second qualifying event such as death or divorce of the employee, or loss of dependent status occurs during the initial 18 month period, the dependents would then be eligible for a maximum of 36 months from the original qualifying event date.

It is the responsibility of the affected dependents to notify the third party COBRA administrator within 30 days, should they be eligible for an extension of COBRA coverage.

PREMIUM PAYMENT

You will have 45 days from the date you sign the election form to pay all retroactive premiums and bring your account to a current status. There is no additional grace period on the due dates for any premiums that fall within this 45 day initial period. The premiums due are all coverage months from your qualifying event date through the end of the 45 day initial payment period.

An initial monthly invoice will be sent to you or the enrolled person as soon as the completed application is processed. Any delay in processing the application does not extend the 45 day payment requirement. **NON-RECEIPT OF THE INITIAL INVOICE DOES NOT NEGATE YOUR RESPONSIBILITY TO MAKE TIMELY PAYMENTS.**

DO NOT WAIT FOR AN INITIAL INVOICE TO MAKE PAYMENT. ALL PAYMENTS SHOULD BE SENT TO THE FOLLOWING ADDRESS:

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

Please be sure to write your Social Security Number on your check.

Deposit of a check does not guarantee coverage. If payment is delinquent or coverage has been terminated, your check will be returned to you.

Upon enrollment, you will continue to receive a monthly invoice until the end of your COBRA eligibility period.

Please note, once you have enrolled in COBRA you are considered **eligible** to receive benefits. However, Delta Dental requires that your account be paid current before authorizing services. If your account is not paid to a current status and you are within your grace period, you may be required to pay for the services received and then submit a claim form for reimbursement.

Questions can be directed to Wolfpack Insurance Services at 1-800-296-0192.

TERMINATION OF COBRA COVERAGE

The period for which continuation coverage has been elected will be terminated upon the earliest of the following events:

APPENDIX F, CSU DENTAL ADMINISTRATIVE GUIDE

- Maximum continuation period expires.
- Failure to pay required premium in a timely manner.
- Enrolled person becomes covered under another group health plan (unless a pre-existing condition exists).
- The CSU ceases to provide any group dental plan for any employee.



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;

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- 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***