

COBRA NOTICE/ELECTION FORM
PMI DELTACARE DENTAL PLAN

This notice is to advise you that your PMI DeltaCare dental coverage 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;
- 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);
- 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

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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 PMI DeltaCare 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 premium billing and coupons 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 BILL OR COUPONS DOES NOT NEGATE YOUR RESPONSIBILITY TO MAKE TIMELY PAYMENTS.**

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

***PMI DeltaCare
12898 Towne Center Drive
Cerritos, CA 90703
(800) 422-4234***

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

All checks are automatically cashed by a bank lock-box. Deposit of a check does not guarantee coverage. If payment is delinquent or coverage has been terminated, a refund check will be issued.

Please note, once you have enrolled in COBRA you are considered **eligible** to receive benefits. However, PMI DeltaCare requires 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 PMI DeltaCare's Customer Service Department at 1-800-422-4234.

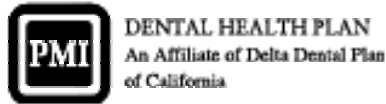
TERMINATION OF COBRA COVERAGE

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

- Maximum continuation period expires.

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- 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:

- e) The expiration of 18 or 36 months following the date coverage ceases (see exception below).
 - f) You are or become covered under another dental plan.
 - g) You fail to pay the monthly premium within 30 days of the due date.
 - h) 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 back of this form and return it to PMI at the address provided below. Also provided below are telephone numbers for all questions and inquiries.

**PMI
12898 Towne Center Drive
Cerritos, CA. 90703**

(800) 422-4234

APPLICANT'S INFORMATION			
Name _____	Social Security Number _____		
Effective Date _____	Birthdate _____	Relationship _____	
Group Name to be Covered Under _____	Group Number _____		

Previously covered under _____
Member Name Member SSN

Employer Name _____ Employer Number (Group #) _____ Date Coverage Ended _____ PMI Dental Office # _____

PLEASE CHECK DESIRED COVERAGE (one selection only):

Employee Only \$ _____

Employee + 1 Dependent \$ _____

Employee + 2 or more Dependents \$ _____

18 months continuation of coverage (member election) 36 month continuation coverage (dependent election)

MAKE CHECK PAYABLE and MAIL to:
PMI
12898 Towne Center Drive
Cerritos, CA. 90703

My first payment is: Enclosed Will be received within 45 days

Please make sure your name appears on the check. Your dental account will not be reactivated until your first payment is received. Once your first payment is received by PMI, a verification letter and monthly payment coupons will be mailed to you. **PLEASE NOTE THAT NO MONTHLY BILLING NOTICES WILL BE SENT TO YOU – YOU ARE RESPONSIBLE FOR TIMELY PAYMENTS.**

List below any dependents that are to be covered:

<u>Name</u>	<u>Relationship</u>	<u>Birthdate</u>	<u>SSN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I, the undersigned, declare that neither I nor my dependents listed above are covered by any other dental plan and that I will immediately notify PMI if I become ineligible for continuation of benefits under C.O.B.R.A.

Applicant's Signature _____ Date _____
 Address _____
 City _____ State _____ Zip _____

- IMPORTANT -
Your first payment MUST be received by PMI 45 following the date you sign this form.