DELTA DENTAL

Please identify who collects COBRA premiums:

- ❑ **Delta Dental collects premiums**
- ❑ **Group collects premiums**

COBRA APPLICATION

LENGTH OF COVERAGE	PREMIUM

Delta Dental of New Jersey, Inc.
P.O. Box 219, Parsippany, NJ 07054
COBRA Inquiries: 973-285-4145

You may continue your dental care coverage by electing to do so and by paying the Total Monthly Contribution Payment. You have until the date 60 days after the later of (a) the date of termination or (b) the date of notice to make that election and **return the completed notice to your prior employer.**

THIS SECTION TO BE COMPLETED BY GROUP ADMINISTRATOR

_____ – _____		
GROUP NUMBER	GROUP NAME	EFFECTIVE DATE OF COBRA COVERAGE

PLEASE INDICATE THE QUALIFYING EVENT BY CHECKING ONE OF THE FOLLOWING:

- ❑ EMPLOYEE DEATH, employee member ID# _____
- ❑ EMPLOYEE MARRIAGE, DISSOLUTION OR LEGAL SEPARATION, employee member ID# _____
- ❑ CHILD NO LONGER AN ELIGIBLE DEPENDENT, covered parent's member ID# _____
- ❑ DEPENDENT OF AN EMPLOYEE ELIGIBLE FOR MEDICARE, employee member ID# _____
- ❑ EMPLOYEE TERMINATION OF EMPLOYMENT OR REDUCTION IN WORK HOURS
- ❑ RETIREE NOT ELIGIBLE FOR MEDICARE
- ❑ DISABLED INDIVIDUAL ELIGIBLE FOR 29 MONTHS OF COVERAGE

_____

Signature of Group Representative (NOTE: APPLICATIONS CANNOT BE PROCESSED WITHOUT AUTHORIZED SIGNATURE) **Date**

THIS SECTION TO BE COMPLETED BY PERSON ELIGIBLE FOR CONTINUATION OF COVERAGE

MEMBER ID NUMBER	LAST NAME	FIRST	INITIAL	BIRTHDATE

MAILING ADDRESS:

_____

Telephone: _____–_____–_____

DEPENDENTS TO BE COVERED:

FIRST NAME	RELATIONSHIP	DATE OF BIRTH	MEMBER ID NUMBER
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	

Are you covered under any other dental program? ❑ Yes ❑ No

If YES, name and address of other carrier: _____

I hereby acknowledge receipt of the formal notification from my employer or group sponsor regarding my right to continuation of dental benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), referred to as COBRA.

❑ I do not wish to have my dental benefits continued. I fully understand that I hereby waive any right to rescind this at a later date and that my dental coverage ceases under the terms of the master contract with Delta Dental of New Jersey, Inc.

❑ I wish to continue my dental benefits as defined in the master contract with Delta Dental of New Jersey, Inc. and as provided under COBRA regulations. I understand that the dental benefits could terminate in accordance with the COBRA regulations that were explained in the formal notification mentioned above.

If I have elected to continue coverage under Delta Dental due to the Qualifying Event as indicated above, I understand that in order to retain coverage I must meet the required payment obligations and/or such other conditions as may be required. Failure to do so will result in automatic termination of benefits.

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Signature of Applicant **Date**