DELTA DENTAL
HDS
Hawaii Dental Service
700 Bishop St. Ste. 700
Honolulu, HI 96813

# COBRA CONTINUATION COVERAGE ELECTION FORM

(Refer to Instructions Attached to This Form)

## SECTION I – Notification and Form Completion (To be completed by the Plan Administrator)

1. Date of Notice: ______________________
2. Name: ______________________ 3. Employee Name (If different): ______________________
4. HDS Dental Benefits will terminate on ______________ 5. Employee SS# ______________________
6. **IMPORTANT: This form must be completed and returned to ______________________, no later than ______________. If mailed, it must be post-marked no later than this date.**
7. Qualifying COBRA Event: (CHECK ONE BOX BELOW)

| EVENT | MAXIMUM LENGTH OF COVERAGE |
|---|---|
| ☐ End of Employment ☐ Retirement ☐ Reduction in hours of employment | Eighteen (18) Months |
| ☐ Divorce/Legal Separation ☐ Death of Employee<br>☐ Loss of dependent child status ☐ Medicare Enrollment of Spouse/Parent | Thirty-Six (36) Months |
| ☐ Certified Disabled by Social Security Act | Twenty-Nine (29) Months |

8. Date of Qualifying Event: ______________ (Mo/Day/Year) 9. Date COBRA Coverage to Begin: ______________ (Mo/Day/Year)
10. Current Monthly COBRA Rates: Single: $__________ Two Party: $__________ Family: $__________ Other: $__________
11. Group Name: ______________________ 12. HDS Group / COBRA Division Number: ___ ___ ___ ___ - ___ ___ ___ ___
13. Plan Administrator: ______________________ 14. Phone Number: ______________________

## SECTION II – Election of COBRA Benefits (To be completed by the Covered Employee and/or Spouse and Dependents) Check one below, sign and return.

☐ **I (We) elect to continue coverage in the Hawaii Dental Service ("HDS") Dental Plan as indicated below and will be responsible for the full cost of the coverage.**

15. List the individuals to be included in the HDS Dental Plan continuation coverage.

| A. RELATIONSHIP TO EMPLOYEE | B. SEX | C. LAST NAME FIRST MIDDLE INITIAL | D. SOCIAL SECURITY # | E. BIRTH DATE | F. Certified Disabled by SSA | Child is over Age Limit |
|---|---|---|---|---|---|---|
| EMPLOYEE | M F | | ___-__-____ | __/__/__ | | |
| SPOUSE | M F | | ___-__-____ | __/__/__ | | |
| DEPENDENT CHILD | M F | | ___-__-____ | __/__/__ | | |
| DEPENDENT CHILD | M F | | ___-__-____ | __/__/__ | | |
| DEPENDENT CHILD | M F | | ___-__-____ | __/__/__ | | |

Checks should be made payable to Hawaii Dental Service. See attached HDS COBRA Payment Procedures for instructions on premium payments. Payment is due the first of each month. Non-payment will result in the termination of this coverage and will not be reinstated. **The monthly COBRA rates are subject to change based upon contracted changes in benefits and rates of the employer group plan.**

I hereby certify that above information is accurate and complete. I have read, understand and agree to all the provisions listed under "important COBRA Information & Payment Procedures" on page 3 of this COBRA enrollment form. (SIGN AND RETURN AS STATED IN #6 ABOVE)

X______________________ ______________ ______________
Signature of COBRA Enrollee (or Guardian) Date Phone (Home)

______________________ ______________ ______________
Print Name Relationship to individual(s) listed above Phone (Work/Other)

______________________________________________
Mailing Address: Number & Street /PO Box City State Zip Code

☐ **I <u>do not</u> wish to continue my coverage under the HDS Dental Plan, for myself and/or my dependents, if any.** (SIGN AND RETURN AS STATED IN #6 ABOVE)

X______________________ ______________
Signature Date

______________________ ______________
Print Name Relationship to individual(s) listed above

# INSTRUCTIONS FOR COMPLETING THE HDS COBRA CONTINUATION COVERAGE ELECTION FORM

| SECTION I (To be completed by the Plan Administrator) | | |
|---|---|---|
| **ITEM #** | **TITLE** | **DESCRIPTION** |
| | Notice of COBRA election rights | Plan Administrator must provide a separate notice of COBRA election rights with this Election Form. |
| 1 | Date of Notice | Date the Qualified Beneficiary is notified of his/her COBRA rights |
| 2 | Name | Name of Qualified Beneficiary |
| 3 | Employee Name | If different from #2, the name of the employee |
| 4 | Coverage Termination Date | Date in which the covered employee and/or spouse and dependents will no longer be eligible to receive benefit services from the active subscriber group plan (Normally the end of the month following the qualifying event) |
| 5 | Employee SS# | Employee's Social Security Number |
| 6 | Return and completion instructions | Return addressee and return date for the HDS COBRA Continuation Coverage Election Form. The return date should be 60 days from the plan termination date or 60 days from the Date of Notice, whichever is later. |
| 7 | Qualifying COBRA event | *For covered employees, spouses or dependent children:*<br>• Termination of employment for reasons other than "gross misconduct"<br>• Retirement from employment<br>• Reduction in hours of employment<br>• Certified disabled by Social Security Act<br>*For spouses or dependent children:*<br>• Divorce / Legal Separation of a spouse from a covered employee<br>• Death of a covered employee<br>• Loss of dependent child status<br>• Covered employee's coverage under Medicare |
| 8 | Date of qualifying event | Date in which the qualifying event occurred |
| 9 | Date COBRA coverage to begin | Date in which the covered employee and/or spouse and dependents will be eligible to receive COBRA benefits (COBRA regulations do not allow for a break in coverage. Coverage must be uninterrupted and shall begin immediately following the termination from the active subscriber group plan) |
| 10 | Current monthly COBRA rates | Current monthly rates plus 2% administration fee |
| 11 | Group name | Name of the subscriber group plan |
| 12 | HDS Group / COBRA Division | HDS group number and applicable COBRA division number |
| 13 | Plan Administrator name | Name of the Plan Administrator completing the HDS COBRA Continuation Coverage Election Form |
| 14 | Plan Administrator phone number | Phone number of the Plan Administrator completing the HDS COBRA Continuation Coverage Election Form |
| **SECTION II (To be completed by the Covered Employee and/or Spouse and Dependents)** | | |
| | Election to accept COBRA | Covered employee and/or spouse and dependents checks election box to accept continuation of coverage<br>Acceptance of responsibility for the full cost of the coverage<br>Acceptance of COBRA rate changes based upon contracted changes in benefits and rates of the employer group plan<br>Acceptance of termination of coverage due to non-payment of monthly premiums |
| 15 | Individuals to be enrolled | Individuals to be enrolled, including A) relationship to employee, B) sex, C) full name, D) Social Security Number, E) birthdate, F) Social Security Disability or Age Limit |
| | Signature | Signature of Qualified Beneficiary or legal guardian electing coverage, including phone number and mailing address |
| | Election to decline COBRA | Covered employee and/or spouse and dependents checks election box to decline continuation of coverage |
| | Signature | Signature of Qualified Beneficiary or legal guardian declining coverage |

Completed forms should be mailed to: Hawaii Dental Service, Attn: COBRA, 700 Bishop St. Ste. 700, Honolulu, HI 96813

# IMPORTANT COBRA INFORMATION & PAYMENT PROCEDURES

## 1. MONTHLY SELF-PAYMENT OF PREMIUMS

A. Payment is the responsibility of the COBRA enrollee. Claims will not be paid by HDS unless the initial payment is received and monthly premium payments are current.

B. Upon enrollment under the COBRA plan, HDS will mail the COBRA enrollee payment coupons. The COBRA enrollee is required to complete the payment coupon and mail it together with the monthly payment by the 1st of the month.

C. Payments must be made by check or money order. Payments are not available through credit cards or automatic bank account deductions initiated by HDS. The COBRA enrollee may contact their financial institution for automatic bill paying services. If payments are made through bill payment services, the check should include the member's ID number.

D. Coupon and checks made payable to HDS should be mailed to:

Hawaii Dental Service
Attention: COBRA
700 Bishop Street, Suite 700
Honolulu, HI 96813

E. Payment for the current month is due and payable to HDS by the first of the month or by the date specified on the payment coupon. If HDS does not receive the current month's premium within 30 days of the due date, eligibility under the COBRA program will automatically terminate. An enrollee who loses eligibility for failure to pay premiums may not re-enroll.

F. Termination of eligibility may result if an enrollee's check is returned unpaid and proper payment is not received.

## 2. CHANGES

The COBRA enrollee is responsible for notifying HDS of any of the following events:

- Change of address
- Divorce, legal separation or change of dependent status or attainment of maximum age (notification must be made within 60 days of the event)
- Becoming covered under another dental plan **after** enrollment in COBRA
- Becoming entitled to Medicare **after** enrollment in COBRA

## 3. BENEFITS

Benefits for the COBRA enrollee will remain the same as for active enrollees in the Employer's program. Consequently, any changes of benefits and/or rates will apply to COBRA enrollees who will be notified by HDS.

## 4. CLAIMS

Claims must be submitted using the COBRA Group/Sublocation number, and using the COBRA enrollee's member number.

## 5. INQUIRIES

For inquiries regarding COBRA payments and eligibility, please contact:

HDS Billing Department

| | |
|---|---|
| Phone: | 529-9285 |
| Toll Free Phone: | (800) 232-2533, extension 285 |
| Fax: | 529-9343 |
| Toll Free Fax: | (866) 721-1951 |

Note: Under Federal Privacy Laws, information regarding a member's COBRA account will not be released to anyone but the member, unless the member has signed a "Authorization to Release and/or Restrict Member Information" Form, which permits the release of information to a specified person.



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