* Required Field

Request to Elect Dental COBRA

EMPLOYER SECTION

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Plan Administrators (the employer) are responsible for administering COBRA continuation coverage. You may use this form to inform us of the intention of a qualified individual to continue group dental coverage. Please complete the employer section of this form and have the qualified individual complete the reverse side and forward the completed form to Sun Life Administrative Office P.O. Box 981624 El Paso, Texas 79998-1624.

This form does not constitute a Notice of COBRA Continuation Rights. If you have questions about your COBRA obligations, please consult your attorney.

Group name* _____

Policy no.* _____ Participation no. _____ Account no. _____ Certificate no. _____

Employee name* _____

Date coverage terminated* _____ Date employer was notified of qualifying event _____

Date qualified individual was notified of COBRA rights* _____

Qualifying Events *(Please check appropriate box.)*

- ☐ Employee terminated employment because of voluntary termination, unapproved leave of absence, lay-off or was dismissed for reasons other than gross misconduct: 18 months
- ☐ Employee's hours were reduced: 18 months
- ☐ Death of the covered employee: 36 months
- ☐ Divorce or legal separation of the covered employee from spouse: 36 months
- ☐ The covered dependent child ceases to be an eligible dependent under the terms of the employer's dental plan: 36 months
- ☐ The occurrence of a second qualifying event. Explain. _____
- ☐ Extension of the 18-month COBRA continuation of coverage period up to a maximum of 29 months due to disability. *(Certificate of entitlement must be submitted as proof of disability.)*

COBRA benefits will be terminated if premiums are not paid in a timely manner or if other group dental coverages are obtained.

Employer's signature _____ Date _____

Sun Life Administrative Office P.O. Box 981624 El Paso, Texas 79998-1624
T 800.733.7879 F 888.208.2323

create barcode

QUALIFIED INDIVIDUAL SECTION

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employees and/or dependents may have the right to continue insurance beyond the date insurance would otherwise terminate. You should contact your employer concerning your right to continue group dental coverage under the employer's plan. If you are eligible to continue your group dental coverage and wish to continue coverage, at your own expense, please complete this form and return it to the employer. This form must also be completed and returned to the employer if continuation of coverage is not elected.

If you or your dependents obtain or are already covered under another group dental plan (that does not exclude or limit coverage for pre-existing conditions) after the date continuation of coverage has been elected, then COBRA continuation will terminate as of the effective date of the other group dental plan.

Please print.

Group name*		Policy no.*	
Participation no.	Account no.	Certificate no.	
Employee name*			
Employee's address—Street*	City	State	Zip

List all qualified individuals to be covered under the continuation and check the coverages to be continued. *(Any qualified individuals that are not listed will not be insured for continuation of coverage.)* Only those coverages that were in effect immediately prior to the date coverage terminated, can be continued. Use a separate sheet of paper if additional space is needed; sign and attach extra copies.

Qualified Individuals	Social Security No.	Date of Birth	Dental
Employee's name			☐
Spouse's name			☐
Dependent's name			☐
Dependent's name			☐

Are you or your dependents covered under another group dental plan? ☐ Yes ☐ No

If "Yes," name of insurance company _____ Effective date _____

IMPORTANT! PLEASE SIGN

☐ I am electing to continue dental coverage as indicated above for those persons named. I understand that it is my obligation to pay all premiums when due in order to secure and maintain continuation of coverage.

I also agree to notify the employer if I or my dependents become covered under another group dental plan.

SIGNATURE DATE

☐ I am waiving my rights to continue all dental coverage for myself and/or my eligible dependents and do NOT wish to elect continuation of coverage.

If all coverage is being waived for employee and/or dependents, the employee and each adult *(18 or over)* dependent MUST sign the form.

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE