DELTA DENTAL

HDS
Hawaii Dental Service

COBRA CONTINUATION COVERAGE ELECTION FORM

(Refer to Instructions Attached to This Form)

Section 1 – NOTIFICATION (To be completed by the Employer/Plan Administrator)

1. COBRA Enrollee Name: _____ 2. COBRA Notification Date: _____
3. Employee Name (If different): _____ 4. Employee Birthdate: _____
5. Qualifying Event Date: _____ 6. HDS Dental Termination Date: _____
7. COBRA Coverage Effective Date: _____
8. 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 ☐ Loss of Dependent Child Status ☐ Medicare Enrollment of Spouse/Parent	Thirty-Six (36) Months
☐ *Certified Disabled by Social Security Administration (Social Security Disability Notice of Award required)	Twenty-Nine (29) Months

9. Monthly COBRA Rates: Single: $_____ Two Party: $_____ Family: $_____ Other: $_____
10. Group Name: _____
11. HDS Group/COBRA Division Number: ___ ___ ___ ___ - ___ ___ ___ ___
12. Employer/Plan Administrator Representative: _____ 13. Phone: _____
14. **IMPORTANT: This form must be completed and returned to _____, no later than _____ (date). If mailed, it must be post-marked no later than this date.**

Section 2 – ELECTION OF COBRA BENEFITS (To be completed by the COBRA Enrollee or guardian) 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. **PLEASE PRINT.**

A. **RELATIONSHIP TO EMPLOYEE**	B. **GENDER (M or F)**	C. **LAST NAME FIRST NAME MIDDLE INITIAL**	D. **DATE OF BIRTH (MM/DD/YYYY)**	E. ***Certified Disabled by SSA (Y or N)**
EMPLOYEE			__ __ /__ __ /__ __ __ __	
SPOUSE			__ __ /__ __ /__ __ __ __	
DEPENDENT CHILD			__ __ /__ __ /__ __ __ __	
DEPENDENT CHILD			__ __ /__ __ /__ __ __ __	
DEPENDENT CHILD			__ __ /__ __ /__ __ __ __	

*Attach a copy of the Social Security Disability Notice of Award letter. If eligibility requirements are met, the length of COBRA eligibility may be extended.

HDS will process the enrollment upon receipt of this form **and** the first month's payment. Make checks payable to Hawaii Dental Service. See attached HDS COBRA Payment Procedures for instructions on premium payments. Non-payment will result in the termination of this coverage. COBRA rates are subject to change based upon contracted changes in benefits and rates of the employer group plan.

Signature Required on Page 2 (Pages 1 & 2 must be completed and submitted for processing)

COBRA CONTINUATION COVERAGE ELECTION FORM

Please read and sign below:

You and Hawaii Dental Service agree that this COBRA Continuation Coverage Election Form may be electronically signed and the electronic signature appearing on this Form is the same as a handwritten signature for purposes of validity, enforceability, and admissibility.

I hereby certify that the information provided is accurate and complete. I have read, understand and agree to all the provisions listed under "Important COBRA Information & Payment Procedures" on page 4 of this COBRA enrollment form. (SIGN AND RETURN AS STATED IN #14 ABOVE)

X_____ _____ _____
Signature of COBRA Enrollee (or Guardian) | Date | Daytime Phone (Work/Other)

_____ _____ _____
Print Name | Relationship to individual(s) listed above | Email Address

_____ _____ _____
Mailing Address: Number & Street /PO Box | City, State | Zip Code

☐ I do not wish to continue my coverage under the HDS Dental Plan, for myself and/or my dependents, if any. (SIGN AND RETURN AS STATED IN #14 ABOVE)

X_____ _____
Signature | Date

_____ _____
Print Name | Relationship to individual(s) listed above

HDS USE ONLY	
MEMBER ID	
GROUP #	
CHECK AMT	
CHECK #	
ENTERED BY	

INSTRUCTIONS FOR COMPLETING THE HDS COBRA CONTINUATION COVERAGE ELECTION FORM

SECTION 1 (To be completed by the Employer/Plan Administrator)		
Item #	Title	Description
	Notice of COBRA Election Rights	Employer/Plan Administrator must provide a separate notice of COBRA election rights with this Election Form
1	COBRA Enrollee Name	Name of Qualified Beneficiary who is eligible for COBRA coverage
2	Date of COBRA Notification	Date the Qualified Beneficiary is notified of his/her COBRA election rights
3	Employee Name	If different from #1, the name of the employee
4	Employee Date of Birth	Birthdate of the employee
5	Date of Qualifying Event	Date in which the qualifying event occurred
6	HDS Dental Termination Date	Date in which the covered employee/spouse/dependent will no longer be covered under the active group plan (Normally the last day of the month following the qualifying event)
7	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)
8	Qualifying COBRA event	*For covered employees, spouses or dependent children:* • Termination of employment for reasons other than "gross misconduct" • Retirement from employment • Reduction in hours of employment • Certified disabled by Social Security Administration – a copy of the Social Security Disability Notice of Award letter must be attached. *For spouses or dependent children:* • Divorce / Legal Separation of a spouse from a covered employee • Death of a covered employee • Loss of dependent child status • Covered employee's coverage under Medicare
9	Current Monthly COBRA rates	Current monthly rates plus 2% administration fee. For individuals determined to be disabled (see #8 above), the COBRA rate for the additional 11 months of COBRA will be increased to 150% of the applicable premium.
10	Group Name	Name of the group or company
11	HDS Group/COBRA Division	HDS group number and applicable COBRA division number
12	Employer/Plan Administrator Representative	Name of the Employer/Plan Administrator representative completing the HDS COBRA Continuation Coverage Election Form
13	Phone Number	Phone number of the Employer/Plan Administrator representative completing the HDS COBRA Continuation Coverage Election Form
14	Return and Completion Instructions	Return address and name of Employer/Plan Administrator representative 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.
SECTION 2 (To be Completed by COBRA Enrollee or Guardian)		
	Election to Accept COBRA	Covered employee and/or spouse and dependents checks election box to accept continuation of coverage. This also indicates acceptance of responsibility to pay the full cost of the coverage, acceptance of COBRA rate changes based upon contracted changes in benefits and rates of the employer group plan, and 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) Gender, C) Full Name, D) Date of Birth, E) *Social Security Disability *The Social Security Disability Notice of Award letter must be provided to HDS. If eligibility requirements are met, the maximum length of COBRA may be extended.
	Signature of COBRA Enrollee or Guardian	Signature of Qualified Beneficiary or legal guardian electing coverage, date signed, including phone number, mailing address and email 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

Mail completed form to: Hawaii Dental Service, Attn: COBRA, 900 Fort Street Mall, Ste. 1900, Honolulu, HI 96813

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HDS
Hawaii Dental Service

COBRA INFORMATION & PAYMENT PROCEDURES

1. MONTHLY 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. The initial payment for continuation coverage must be received no later than 45 days after the date of election (which is the date the Election Notice is postmarked.) If payment is not received within 45 days after date of election, enrollee will lose all continuation coverage rights under the plan.

B. Upon enrollment under the COBRA plan, HDS will mail the COBRA enrollee payment coupons. The payment coupon must be completed and mailed together with the monthly payment by the first of each month.

C. Payments must be made by check or money order. Payments are not available through credit card or automatic bank withdrawals initiated by HDS. The COBRA enrollee may arrange automatic bill payment services with their financial institution. Automatic bill payments must include the enrollee's HDS Member ID number.

D. Payments (and the monthly coupon) should be made payable to HDS and mailed to:

Hawaii Dental Service
Attention: COBRA
900 Fort Street Mall, Ste. 1900
Honolulu, HI 96813

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

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

2. ENROLLEE RESPONSIBILITIES

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
- Certified disabled by the Social Security Administration or end of such disability. A copy of the Social Security Disability Notice of Award letter must be provided to HDS. If eligibility requirements are met, the maximum length of COBRA may be extended from 18 to 29 months.

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.

4. CLAIMS

Claims must be submitted using the COBRA enrollee's member ID number.

5. INQUIRIES

For inquiries regarding COBRA payments and eligibility, please contact the HDS Billing department at:

Email:	HDSBilling@HawaiiDentalService.com
Phone:	(808) 529-9285
Toll Free Phone:	(844) 379-4326
Fax:	(808) 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 an "Authorization to Release and/or Restrict Member Information" Form, which permits the release of information to a specified person.