

## COBRA CONTINUATION COVERAGE ELECTION FORM

(Refer to Instructions Attached to This Form)

| COBRA Enrollee N   | Name:   |   | 2. COBRA Notif   | ication Date:   |   |
|--|---|---|--|---|---|
| Employee Name (  | (If different):   |   | 4. Employee Bir  | rthdate:  |   |
| Qualifying Event [   | Date:   |   | 6. HDS Dental 1  | ermination Date:  |   |
| COBRA Coverage   | Effective Date:   |   |  |   |   |
| Qualifying COBRA   | A Event: (CHECK ONE BO  | X BELOW)                                      |  |   |   |
|  | EVI   | ENT   |  | MAXIMUM LENGTH OF   | COVERAG   |
| ☐ End of Emplo   | oyment  | Reduction in H                                | ours of Employment                                     | Eighteen (18) M   | onths   |
|  | al Separation   | eath of Employee<br>edicare Enrollment of S   | Spouse/Parent  | Thirty-Six (36) N   | 1onths  |
| _  | sabled by Social Security vard required)  | Administration (Social                        | Security Disability                                    | Twenty-Nine (29)  | Months  |
| Monthly COBRA F  | Rates: Single: \$   | Two Party: \$                                 | Family: \$   | Other: \$   |   |
| Group Name:  |   |   |  |   |   |
| HDS Group/COBF   | RA Division Number:   |   |  |   |   |
| Employer/Plan Ad   | dministrator Representativ  | /e:   |  | 13. Phone:  |   |
|  | (date). If mail   | ed and returned to _<br>ed, it must be post-m |  | , no<br>his date.   | later than  |
| tion 2 - ELECT<br>ck one below,<br>Ve) elect to continuthe full cost of the  | (date). If mails  ION OF COBRA BEN  sign and return.  | NEFITS (To be co                              | ompleted by the Down Dental Plan as i                  | cobra Enrollee or   | guardia   |
| ve) elect to continue the full cost of the   | ion of cobra bendered in the Haward coverage.  B. C.  | NEFITS (To be co                              | ompleted by the Down Dental Plan as i                  | cobra Enrollee or   | guardia<br>be respon                              |
| ve) elect to continue the full cost of the   | (date). If mails  ION OF COBRA BEN sign and return.  The coverage in the Hawa e coverage.  als to be included in the      | NEFITS (To be co                              | ompleted by the Down Dental Plan as i                  | his date.  COBRA Enrollee or  ndicated below and will  LEASE PRINT.                   | guardiar be respon  E. *Certifi                   |
| ve) elect to continue the full cost of the List the individual A.  RELATIONSHIP  | ION OF COBRA BENSIGN and return.  The coverage in the Hawas coverage.  als to be included in the  B. C.  GENDER LAST NAME | NEFITS (To be co                              | ompleted by the DS") Dental Plan as inuation coverage. | COBRA Enrollee or ndicated below and will LEASE PRINT.                                | be respon  E. *Certifi Disablec SSA (Y c          |
| ve) elect to continue the full cost of the List the individual A.  RELATIONSHIP TO EMPLOYEE  | ION OF COBRA BENSIGN and return.  The coverage in the Hawas coverage.  als to be included in the  B. C.  GENDER LAST NAME | NEFITS (To be co                              | ompleted by the DS") Dental Plan as inuation coverage. | COBRA Enrollee or ndicated below and will LEASE PRINT.  DATE OF BIRTH (MM/DD/YYYY)    | be respon  E. *Certific Disables SSA (Y c         |
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| tion 2 - ELECT ck one below, so the below, so the below, so the below, so the below of the below the full cost of the below the full cost of the below the b | ION OF COBRA BENSIGN and return.  The coverage in the Hawas coverage.  als to be included in the  B. C.  GENDER LAST NAME | NEFITS (To be co                              | ompleted by the DS") Dental Plan as inuation coverage. | COBRA Enrollee or ndicated below and will LEASE PRINT.  DATE OF BIRTH (MM/DD/YYYY)    | be respon  E. *Certifi Disabled SSA (Y c          |

HDS will process the enrollment upon receipt of this form <u>and</u> the first month's payment. <u>Make checks payable to Hawaii Dental Service</u>. 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)

CHILD

<sup>\*</sup>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.

### 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)

| Signature of COBRA Enrollee (or Guardian)       | Date C                                      | Daytime Phone (Work/Other)      |
|---|---|---------------------------------|
| Print Name                                      | Relationship to individual(s) listed abo    | ve Email Address                |
| Mailing Address: Number & Street /PO Box        | City, State                                 | Zip Code                        |
| I do not wish to continue my coverage under the | e HDS Dental Plan, for myself and/or my dep | endents. if anv. (SIGN AND RETU |
| AS STATED IN #14 ABOVE)                         |   |                                 |
|   | -<br>Date                                   |                                 |

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

#### INSTRUCTIONS FOR COMPLETING THE HDS COBRA CONTINUATION COVERAGE ELECTION FORM

| Nestice of COBRA Election   Employee/Plan Administrator must provide a separate notice of COBRA election fights with this Election Form  | IINS  |                                 | be completed by the Employer/Plan Administrator)  |  |  |  |
|--|---|---------------------------------|---|--|--|--|
| Rights   Fights with this Election Form  | Item #  |                                 |   |  |  |  |
| 2 Date of COBRA Notification Date the Qualified Beneficiary is notified of his/her COBRA election rights 3 Employee Name If different from #I, 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 Qualifying event occurred 6 HDS Dental Termination Date Date in which the Qualifying event occurred under the active group plan (Normally the last day of the month following the the CoBRA Coverage to Begin Cobre in which the covered employee and/or spaces and dependent will be aligible to the county of the county of the coverage. Coverage must be uniterrupted 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 for reasons other than "gross misconduct" • Retirement from employment or reasons other than "gross misconduct" • Retirement from employment or reasons other than "gross misconduct" • Retirement from employment or associated the properties of the county plantality Notice of Avaria (letter must be attached. For spouses or dependent children: • Death of a covered employee • Covered employees coverage under Medicare  Covered employees coverage under Medicare  Current Monthly COBRA rates  Current monthly rates glus 28 administrator fie. For individuals determined to be disabled for the detail of the properties of the additional 11 months of COBRA will be increased to 150% of the applicable premium.  10 Group Name  Name of the group or comeany  HDS group interminent and applicable COBRA division number  HDS Group/COBRA Division  Phone Number  Phone Number  Phone Number  Phone number of the Employer/Plan Administrator representative completing the HDS COBRA Continuation Cover |   |                                 |   |  |  |  |
| Employee Name  | 1   | COBRA Enrollee Name             | Name of Qualified Beneficiary who is eligible for COBRA coverage  |  |  |  |
| 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 qualifying event occurred 7 Date COBRA Coverage to Begin Coverage to Begin Coverage (Spender) 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:  | 2   | Date of COBRA Notification      | Date the Qualified Beneficiary is notified of his/her COBRA election rights   |  |  |  |
| Date in which the qualifying event occurred  Date in which the covered employee/spouse/dependent will no longer be covered unalifying event)  Date in which the covered employee/spouse/dependent will no longer be covered qualifying event)  Date in which the covered employee/spouse/dependent will no longer be covered qualifying event)  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).  B Qualifying COBRA event  For covered employees, spouses or dependent children:  - Termination of employment for reasons other than "gross misconduct"  - Retizement from employment  - Certified disabled by Social Security Administration - a copy of the Social Security Disablity 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? - Death of a covered employee in the death of             | 3   | Employee Name                   | If different from #1, the name of the employee  |  |  |  |
| Bosephage   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)  | 4   | Employee Date of Birth          | Birthdate of the employee   |  |  |  |
| 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 beautiful 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 and/or spouses or dependent children:  • Termination of employment for reasons other than "gross misconduct" Returnment from employment for reasons other than "gross misconduct" Returnment from employment  • Returnment from employment  • Returnment from employment  • Divorce / Legal Separation of a spouse from a covered employee  • Death of a covered employee so dependent child status  • Covered employee's coverage under Medicare  Quirrent Monthly COBRA rates  Group Name Name of the group or company  10 Group Name Name of the group or company  11 HDS Group/COBRA Division  12 Employer/Plan Administrator  Representative  Phone Number Phone number 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  15 Individuals to be Enrolled Coverage States  Covered employee and/or spouse and dependents checks election box to accept continuation of coverage to 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 to pay the eligibility requirements are met, the maximum length of COBRA more defined, including hone number, mailing address and enall address.  Signatu | 5   | Date of Qualifying Event        | Date in which the qualifying event occurred   |  |  |  |
| Begin  | 6   | HDS Dental Termination Date     | under the active group plan (Normally the last day of the month following the   |  |  |  |
| 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 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.  Mame of the group or company HDS Group/COBRA Division HDS group number and applicable COBRA division number Representative COBRA Continuation Coverage Election Form Representative Return and Completion Instructions Return and Completion Return address and name of Employer/Plan Administrator representative completing the HDS COBRA Continuation Coverage Election Form  SECTION 2 (To be Completed by COBRA Enviruation Coverage Election Form  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 plan, and acceptance of termination 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 plan, and acceptance of termination 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. This also indicates acceptance of COBRA rate changes based upon contracted cha  | 7   |                                 | to receive COBRA benefits. (COBRA regulations do not allow for a break in coverage. Coverage must be uninterrupted and shall begin immediately following  |  |  |  |
| 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.  Mame of the group or company  HDS Group/COBRA Division  HDS group number and applicable COBRA division number  Representative  Phone Number  Phone Number  Phone Number  Phone number of the Employer/Plan Administrator representative completing the HDS COBRA Continuation Coverage Election Form  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. It is 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 or overage. This also indicates acceptance of responsibility to pay the full cost of Birth. Ib "Social Security Disability" The Social Security Disability Name, D) Date of Birth. Ib "Social Security Disability Temployee, B) Gender, C) Full Name, D) Date of Birth. Ib "Social Security Disability To COBRA may be extended.  Signature of COBRA Enrollee  Signature of Qualified Beneficiary or legal guardian electing coverage, date signed, including phone number, mailing address and dependents checks election box to decline continuation of coverage.  Signature of Qualified Beneficiary or legal guardian declining coverage.   | 8   | Qualifying COBRA event          | <ul> <li>Termination of employment for reasons other than "gross misconduct"</li> <li>Retirement from employment</li> <li>Reduction in hours of employment</li> <li>Certified disabled by Social Security Administration - a copy of the Social Security Disability Notice of Award letter must be attached.</li> <li>For spouses or dependent children:</li> <li>Divorce / Legal Separation of a spouse from a covered employee</li> </ul> |  |  |  |
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| 11 HDS Group/COBRA Division HDS group number and applicable COBRA division number 12 Employer/Plan Administrator Representative 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, 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  Signature of COBRA  Covered employee and/or spouse and dependents checks election box to decline continuation of coverage  Signature of Qualified Beneficiary or legal guardian declining coverage   |   | Carrent Floriding CODIO (Fates) | disabled (see #8 above), the COBRA rate for the additional 11 months of COBRA will  |  |  |  |
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| Representative  COBRA Continuation Coverage Election Form  Phone Number  Phone number of the Employer/Plan Administrator representative completing the HDS COBRA Continuation Coverage Election Form  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  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  Signature of Qualified Beneficiary or legal guardian electing coverage, date signed, including phone number, mailing address and email address.  Covered employee and/or spouse and dependents checks election box to decline continuation of coverage  Signature  | 11  | HDS Group/COBRA Division        | HDS group number and applicable COBRA division number   |  |  |  |
| HDS COBRA Continuation Coverage Election Form  | 12  |                                 |   |  |  |  |
| Instructions   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)   | 13  | Phone Number                    |   |  |  |  |
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| 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 Gualified 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   |   | Election to Accept COBRA        | 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   |  |  |  |
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| or Guardian 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   |   |                                 |   |  |  |  |
| continuation of coverage  Signature Signature of Qualified Beneficiary or legal guardian declining coverage  |   | · ·                             |   |  |  |  |
|  |   | Election to Decline COBRA       |   |  |  |  |
|  |   | ~                               |   |  |  |  |

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

# A DELTA DENTAL

#### **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.