MetLife®

Election Form for Continuation of Dental Coverage in California (Cal-COBRA)

For Employees and Dependents

Qualifying Event (Check One):

[ ] Termination of Employment
[ ] Reduction of Hours
[ ] Employee Eligible for Medicare
[ ] Divorce or Legal Separation
[ ] Death of an Employee
[ ] Eligible for Disability under the Social Security Act (Employee or Dependent)
[ ] Child Ceasing to be Dependent Under Plan

36 Month Period Maximum

Part A – This Part to be completed by Employer or Plan Administrator (please print clearly)

Return this signed and completed form with all appropriate premium payments to:

MetLife
PO Box 14593
Lexington, KY 40512

Employer Name _____
Attention _____
Address _____
Address _____
MetLife Customer Number _____
Employee Name _____
Date of Qualifying Event _____
Date Notice Provided to Employee _____
Date Coverage Will End if Continuance is Not Elected _____
Date Coverage Will End if Continuance is Elected _____
Last Day to Elect Coverage (31 Days After Date of Qualifying Event) _____

COST

The premium includes both the Employee and Employer contributions under the plan, and is based on the current plan plus 10%. Coverage and rates are both subject to change. Dental Coverage may be continued for only the Employee that is actually insured on the date the Qualifying Event occurred.

Available Coverage	**Single Rate** (One Qualified Beneficiary)	**Family Rate** (Two or More Qualified Beneficiaries)
Dental		
Total Monthly Cost to Qualified Beneficiary		

_____
Signature of Authorized Representative of Employer

Part B – This Part to be completed by Employee – Be sure to complete ALL requested information and return completed form with your premium payment to your Employer for submission to MetLife. Payment is to be sent to the Employer at the above address by the 1st of each month.

Name _____ Social Security No. _____

[ ] **I DO** elect to continue coverage provided under the Continuation of Dental Coverage Available in California. I understand that I am responsible for paying the premium by the 1st of each month and providing _____ with all required information.
(Company Name)

[ ] I hereby Waive my right for Continued Dental Coverage Available in California.

Continue coverage for the following covered person checked below:

[ ] Employee Only
[ ] Spouse Only
[ ] Child(ren) Only
[ ] Employee and Spouse
[ ] Spouse and Chil(ren)
[ ] Employee, Spouse and Child(ren)

List below names of all qualified beneficiaries to be covered:

Name (First, MI, Last)	Sex (M/F)	Date of Birth (Mo/Day/Year)	Social Security No.	Relation to Employee

Amount Enclosed $ _____ (see above for your Total Monthly Cost). Be sure to include premium from the date continuation begins through the present month. Make your check payable to _____ and deliver or mail it to the company address.
(Company Name)

_____ _____
Signature Employee Name (please print clearly)

_____ _____
Your Address Date

_____
City State Zip

DNCONT CA (0503)