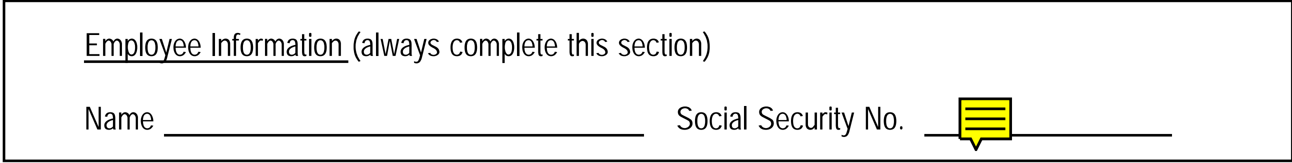
Election Form for Continuation Coverage Available Under Federal Law (COBRA)

Return this signed form to ______________ Be sure to complete ALL requested information.
(company name)



Employee Information (always complete this section)

Name ________________________________ Social Security No. ________________

[ ] I DO elect to continue coverage provided under the Group Dental Plan. I understand I am responsible for paying the premium by the 1st of each month and providing ________________ with all required information.
(company name)

Continue coverage for the following covered person(s) checked below:

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

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 reverse side 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 address shown on the reverse side.
(company name)

Signature ____________________ Date ____________________

Your Address ____________________ Customer Number (see reverse) ____________________

City State Zip ____________________ Employer Name (see reverse) ____________________

REFUSAL STATEMENT

[ ] I hereby WAIVE my rights to continue Group Dental coverage under Federal Law (COBRA).

Signature of Employee ________ Date ________ Signature of Child (18 or older) ________ Date ________

Signature of Employee ________ Date ________ Signature of Child (18 or older) ________ Date ________

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THIS SIDE FOR COMPLETION BY EMPLOYER OR PLAN ADMINISTRATOR

Employer Name ____________________

Attention ____________________

Address ____________________

Metropolitan Customer Number ____________________

Qualified Beneficiary Name ____________________

Date of Qualifying Event ____________________

Qualifying Event (check one):

18 Month Period Maximum

[ ] Termination of Employment

[ ] Reduction of Hours

36 Month Period Maximum

[ ] Divorce or Legal Separation

[ ] Death of Employee

[ ] Child Ceasing to be Dependent Under Plan

[ ] Employee Eligible for Medicare

Date Coverage Will End if Continuance is Not Elected: ____________________

Last Day to Elect: ____________________

COST

The premium includes both the employee and employer contributions under the plan, and is based on the current plan. Coverage and rates are both subject to change. Payment is to be sent to the employer at the above address by the 1st of each month.

Fill in below the total charge for which the qualified beneficiary is responsible. Medical coverage can be elected independently. Dental coverage can only be elected independently if you give an active employee the right to elect dental without medical.

Only those coverages that were in effect at the time the qualifying event occurred may be continued. And, only those persons actually insured on the date the qualifying event occurred can be continued. New eligible dependents may be added in accordance with the provisions of the group plan.

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

____
Signature or Authorized Representative of Employer

____
Date Notice Provided to Qualified Beneficiary