Group/Sublocation Number

EMPLOYER'S NOTICE
to Northeast Delta Dental
COBRA ELECTION

DELTA DENTAL®

SECTION I: TO BE COMPLETED BY EMPLOYER

Social Security Number		COBRA Effective Date	Termination Date	Notification Date
Name	Address			
City	State	ZIP Code	Telephone Number	

QUALIFYING EVENT

- ☐ Reduction in Work Hours
- ☐ Termination of Employment
- ☐ Social Security Disabled
- ☐ Bankruptcy under Chapter 11
- ☐ Death of Employee
- ☐ Dependent ceasing to be eligible
- ☐ Employee covered for Medicare
- ☐ Legal Separation or Divorce
- ☐ Retirement (Employee over age 65)

_____

Signature of Plan Administrator

SECTION II: EMPLOYEE/DEPENDENT ELECTION

I have read the Notice of Federal Continuations Rights, and as one of the qualifying events applies to me, I am exercising my continuation rights based on my qualifying event as noted above.

YES ☐ I elect to continue group dental benefits NO ☐ I do not wish to continue dental benefits

_____ _____

Subscriber Signature Date

TYPE OF COVERAGE (PLEASE CIRCLE ONE)

1 - Subscriber Only 2 - Subscriber & Spouse 3 - Subscriber, Spouse & Children
5 - Subscriber & Child 6 - Subscriber & Children

List below only those individuals applying for coverage	Relationship (to employee)	Social Security Number	Date of Birth
Employee (Full Name)	(Self)		
Eligible Dependent (Full Name)			
Eligible Dependent (Full Name)			
Eligible Dependent (Full Name)			
Eligible Dependent (Full Name)			
Eligible Dependent (Full Name)			
Eligible Dependent (Full Name)			
Eligible Dependent (Full Name)			