Application for Continuation of Group Dental Coverage (COBRA)

With the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer sponsored group health plans are required to offer employees and dependents losing eligibility the option to continue their coverage. If you wish to extend coverage, you must complete this form and return it to Delta Dental of Kansas. *You will then receive a coupon booklet from Delta Dental or payment requests from the group.*

To Be Completed By Applicant (Please Print or Type Legibly)

Name (Last, First, Middle Initial):	Social Security Number:	Date of Birth:	Male ☐ Female ☐
Home Street Address:	City:	State:	Zip:
Primary Phone:	Email Address:		

☐ *(check if interested)* Yes, I'd like to receive benefit information, including explanation of benefits online. We value your privacy and use a variety of security measures to protect your personal information. Your email will not be sold or used in any way except for Delta Dental communications. You may change your consent at any time, or request paper documents, by visiting the Subscriber Connection section of our website. There are no conditions, consequences or fees for withdrawing your consent. You have the right to receive your documents in paper form. If you receive electronic documents, you will need access to hardware and software that supports Internet Explorer 7 or Firefox. Additionally, either your web browser or a suitable plugin for opening a file in portable document format such as Adobe Reader is required. You may update your electronic contact information by calling Customer Service at 800.234.3375, emailing moreinfo@deltadentalks.com or logging into the Subscriber Connection at www.deltadentalks.com.

Please list below all persons who are to be covered.

Last Name (if different)	First Name	Middle Initial	Sex (M/F):	Date of Birth	Indicate if covered by other dental insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Signature of Applicant: ________________________________ Date: __________________________

☐ Yes, I want to continue my dental coverage.

☐ No, I do not want to continue my dental coverage.

☐ Return form to Human Resources Administrator.

☐ Return form to Delta Dental of Kansas.

To Be Completed By Employer	
Member ID # on previous Delta Dental coverage:	Date:
Group Name & Number:	Date of Qualification:

Reason for Loss of Eligibility (Please check one. NOTE: Applications cannot be processed without this information):

Standard Length of Coverage – 18 months

☐ End of Employment ☐ Retirement

☐ Reduction in hours of employment

Standard Length of Coverage – 36 months

☐ Divorce/Legal separation ☐ Loss of dependent child status

☐ Medicare enrollment of spouse/parent ☐ Death of employee

Employer Signature:	Title:	Date:

Applicant Eligible for _____months of coverage. COBRA eligibility to terminate on _________________________.

Please mail form to: Delta Dental of Kansas • COBRA Eligibility • PO Box 789769 • Wichita, KS 67278-9769 Or Fax to: 316-462-3394 (Eligibility Department-COBRA)