DELTA DENTAL®

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:		

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

Subscriber's 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):

☐ Lay Off ☐ Divorce or Legal Separation ☐ Reduction of Hours ☐ Retired
☐ Termination ☐ Child Reached Age Limit ☐ Death of Employee ☐ Other:

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)