EXECUTIVE DENTAL & VISION

The Dental Plan Everyone Is Smiling About

Underwritten By DENTCARE DELIVERY SYSTEMS, INC.

Co-Administered By Healthplex® Leadership in Dental Plans

225 Wireless Boulevard, Suite 200, Hauppauge, NY 11788
Phone: (631) 951-9200 Fax: (631) 656-2558

COBRA CONTINUATION FORM

Company Name_____ Policy #_____

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Initial_____

Address _____ City _____ State_____ Zip_____

Home Phone_____Work Phone_____

Social Security # _____/_____/_____ D.O.B. _____/_____/_____ Sex M____ F____ Date Employed ____/____/____

COBRA INFORMATION

I Am Requesting To Continue My Dental Coverage For ☐ Myself ☐ Myself And Eligible Dependents

☐ I Choose ***Not*** To Continue Coverage.

IF CONTINUING COVERAGE

Premiums Payable Monthly Single $_____ Two Party $_____Family $_____

Date Of Termination ____/ ____/ ____

Date COBRA Effective ____/ ____/ ____

Qualifying Event

EMPLOYEE SIGNATURE **X** _____ Date: ____/ ____/ ____

EMPLOYER SIGNATURE **X** _____ Date: ____/ ____/ ____

IMPORTANT **Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application.**

Rev 01/07