



**COBRA Election Form for American Recovery and Reinvestment ACT of 2009 (ARRA) for Groups with less than 20 Full-Time Employees**

**Instructions:** To apply for COBRA ARRA Premium Reduction, complete this form and return it to your employer. You have 60 days from the date your employment ended to elect COBRA coverage. If you do not make an election within 60 days, you will lose your right to elect COBRA continuation coverage. If you are not eligible for COBRA premium subsidy under ARRA, you should not use this form. Use a Membership Maintenance form to apply for non-COBRA premium subsidy benefits.

**EMPLOYEE INFORMATION**

**Effective Date Enrolling in ARRA**      /      /

<b>Employee's Name:</b> Last First Middle Initial		<b>Social Security Number</b>	
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		<b>Date of Birth (Month-Day-Year)</b>
<b>Employee's Address:</b>	Address		Day Phone Number
	City	State	Zip Code

**Check Yes or No for each statement. To qualify, you must be able to indicate "Yes" for all of the following statements for yourself and any dependents who are being enrolled.**

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. I am NOT eligible for other group dental coverage (or I was not eligible for other group dental coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**DEPENDENT INFORMATION – List dependents who are being enrolled for COBRA coverage.**

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different from Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
		M	F		Y	N	Y	N
Spouse				/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

**EMPLOYEE SIGNATURE – Sign and date form as verification of your employment change and COBRA election.**

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct. I have elected to continue coverage under this plan, and I understand that in order to retain my COBRA continuation coverage, I must meet the required payment obligations and/or other conditions as required. Please note: If you become eligible under other group dental coverage, you must request termination of COBRA coverage. If you fail to notify your employer of becoming eligible for other dental coverage and continue to pay reduced COBRA premiums, you may be subject to a fine of 110% of the amount of the premium reduction. You may also be responsible for repayment of any paid claims.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Employer or Plan Use Only – This part to be completed by Employer or Plan and forwarded to Delta Dental of Nebraska PO Box 330 Minneapolis MN 55440-0330.**

This application is:  Approved  Denied  Approved for some/denied for others (explain in #4 below) Specify reason below and then return a copy of this form to the applicant.

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Individual elected COBRA continuation coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Other (Please explain):	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Number of full-time employees employed at your company? \_\_\_\_\_

**Note: If less than 20 Full-Time Employees,** Delta Dental of Nebraska will create a new subgroup and will enroll this COBRA applicant under this subgroup. Delta Dental of Nebraska will report and collect the 65% subsidy from the IRS. After nine months, Delta Dental of Nebraska will transfer members to Standard COBRA Subgroup unless you notify us with a termination notice on a Membership Maintenance Form.

<b>Group Name:</b>	<b>Group &amp; Subgroup Numbers:</b>
<b>Group Representative's Signature:</b>	<b>Date:</b> <b>Phone Number:</b>