DELTA DENTAL OF PUERTO RICO, INC.
Group Dental Health Continuation Enrollment Form

APPLICANT INFORMATION

Last Name First M.I.	Date of Birth (MM/DD/YY)	Sex ☐ M ☐ F	Social Security **(Required)**
Number and Street Address	City	State	Zip Code
The Applicant is: ☐ Part Time Employee ☐ Terminated Employee ☐ Surviving Spouse ☐ Former Spouse ☐ Dependent Child			
Name of Employee and Social Security (**Required** if Different than applicant)		Telephone Number	

ELEGIBILITY:

QUESTION: Are you, or any other family member applying for coverage, now covered under or now eligible to participate under any of the following insurance policies, contracts, or plans which provide benefits similar to those applied for under the Employers Health Benefit Plan terminating on the date certified at the bottom of this form?

a. Medicare or other government plan. ☐ Yes ☐ No

b. Group insurance policy or contract. ☐ Yes ☐ No
If you or an eligible dependent are eligible to participate under another group plan whether your own or your Spouse or whether insured or non-insured, you or that dependent is not eligible to be insured under this Plan.

PLAN SELECTION

I ELECT COVERAGE FOR:

☐ Applicant Only ☐ Applicant and Family ☐ Choose Not to Participate

Benefits to be continued after an applicant or family member become eligible for Medicare? ☐ Yes ☐ No

CALCULATION OF MONTHLY CONTRIBUTION

A. NAME OF APPLICANT	DATE OF BIRTH	MONTHLY RATE
B. NAME OF SPOUSE (If Family Coverage Applied For)	DATE OF BIRTH	MONTHLY RATE
C. NAME(S) OF DEPENDENT CHILD(REN)	DATE OF BIRTH	MONTHLY RATE
		TOTAL MONTHLY RATE

MAKE YOUR CHECK PAYABLE TO: DELTA-COBRA DENTAL PLAN

I hereby make application to extend my health coverage under the terms of the Delta-Cobra Delta Plan, and agree to make the monthly contribution payments for as long as I am eligible. I attach one monthly contribution payment for the first month of coverage. I agree to make any future payments in advance and in a timely fashion. I understand this health coverage will terminate if payment is not made when it is due. Checks are to be made payable to **DELTA-COBRA**, Metro Office Park 14 Calle 2 Suite 200, Guaynabo, PR, 00968

_____ _____

Applicant's Signature Date

TO BE COMPLETED BY EMPLOYER (Required)

It is hereby certified that the above applicant is eligible for the benefits for which application is made. Expiration Date:		
	Coverage with us terminated on:	Employee Number:
Name of Employer (If subsidiary, name of Parent Company)		Group Number
Signature of Authorized Representative		Date

FOR ADMINISTRATION USE

New Claim Branch	Effective Date	By	Date