Federal and State COBRA Election Enrollment Form

Use this form for electing enrollment under COBRA/Cal-COBRA following qualifying event.
Mail to: Premier Access Membership Accounting, P.O. Box 659020, Sacramento, CA 95865-9020 or fax to: (877) 648-7748

Current Group Number:

Coverage Elected: *(You must be currently covered to continue benefits under COBRA.)*

- ❑ Premier* Standard
- ❑ Premier Standard with Orthodontia Rider *(you must currently have orthodontia coverage)*

Qualifying Event:

- ❑ Termination of Employment (Date of Termination: _____)
  (Termination for gross misconduct is not a qualifying event for COBRA.)
  Disabled at time of termination? ❑ Yes ❑ No
- ❑ Reduction in Hours Below Qualifying Amount (Date of Reduction: _____)
  Disabled at time of reduction? ❑ Yes ❑ No
- ❑ Death of Employee (Date of Death: _____)
- ❑ Divorce or Legal Separation (Date of Divorce or Legal Separation: _____)
- ❑ Termination of Status as Dependent Child (Date of Change in Status: _____)
- ❑ Employee Entitled to Medicare Benefits (Date of Entitlement: _____)
- ❑ Employer Filed for Reorganization Under Chapter XI of the Bankruptcy Law (Date of Filing: _____)
  (Federal COBRA only.)

Subscriber Information (Employee, unless COBRA eligible person is not the Employee/Former Employee):

Social Security Number: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

E-mail Address: _____

Date of Birth: _____ Sex: ❑ M ❑ F

Employer/Former Employer (Company) Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Are you continuing coverage for your dependents? ❑ Yes ❑ No *(if yes, complete information below for those dependents who were covered under your group dental plan)*

Relationship to Subscriber	Last Name	First Name & MI	Date of Birth	Sex (M/F)	If dependent is over 19 years of age, check applicable category and attach supporting documentation.	
					Between 19 & 24, full-time student and IRS dependent	Over 19, disabled and fully supported
Spouse						
Dependent Child					❑	❑
Dependent Child					❑	❑
Dependent Child					❑	❑
Dependent Child					❑	❑

Please read and sign the statement on the reverse.

* *All references to "Premier" herein refer to Premier Access Insurance Company*

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Other Dental Coverage Information

Name of Insured: _____ Social Security Number: _____

Insured's Employer: _____

Employer's Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name of Insurance Carrier: _____

Are your dependent children enrolled under your spouse's dental plan? ❑ Yes ❑ No

❑ I/we do not have other dental coverage.

Federal COBRA: Employer groups with 20 or more Employees as defined in Federal COBRA 1985 are eligible for continuing benefit coverage. (Premier does not administer COBRA for Federal COBRA groups, but continues coverage for qualified individuals.)

State COBRA (Cal-COBRA): Employer groups with less than 20 Employees on at least 50% of its working days during the preceding Calendar Year as defined in SB719 are eligible for continuing benefit coverage. (Upon receipt of a COBRA Election Enrollment Form verifying a qualifying event for a qualified beneficiary, Premier administers COBRA for Cal-COBRA groups, and continues coverage for qualified individuals.)

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

PLAN REQUIREMENTS: I, on my behalf and on behalf of my dependent(s) on this enrollment application, agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier Certificate of Insurance. I agree that if I receive dental services after my coverage is terminated or lapses, that I am responsible for any payments made by Premier for such services. Each premium payment after the first payment is due on the first of the month. Failure to make timely payment within the stated due dates will result in termination of coverage.

MANDATORY BINDING ARBITRATION: I UNDERSTAND THAT IN THE EVENT A DISPUTE ARISES BETWEEN MYSELF, AND/OR MY Dependent(s), and Premier, the same shall be settled by neutral, binding arbitration as set out in the Premier Certificate of Insurance.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. This authorization shall remain in effect for the term of my and my Dependent(s) enrollment.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage or by the act or omission of another person, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided. I further agree that in the event I or any of my Dependent(s) collect benefits or damages from any other party who has primary responsibility for services provided by Premier, I will immediately reimburse Premier to the extent of services and supplies received.

NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, may be guilty of a crime and may be subject to fines and confinement in prison.

I authorize the benefit election I have selected. I certify that I am electing only those coverages that were in effect on the day before the Qualifying Event, and that I understand that I will no longer be eligible for COBRA continuation coverage if I become entitled to Medicare, or become covered under another group insurance plan that does not contain a limitation or exclusion due to a preexisting condition. I agree to remit the full current premium to Premier by the specified due dates, and I understand that coverage will be cancelled if timely remittance of premiums is not made, and that reinstatement of coverage is not available if coverage is cancelled for non-payment of premium. I further understand that Premier will bill monthly and this bill is for my convenience only and that I am responsible for timely payment regardless of whether or not I have received a bill. I agree to notify Premier in writing of any change regarding address, eligibility, dependent status or disability status. I agree to be bound by the terms and conditions of the group contract and understand that this application is hereby made a part of the group contract. I certify that the above statements are complete and accurate to the best of my knowledge. I understand that Premier reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment application.

Employee Signature: _____ ***Date:*** _____