UNIVERSITY OF WISCONSIN SYSTEM
DENTALBLUE CONTINUATION FORM

Employee Name	Applicant Name (if different from employee name)
Applicant Address	Applicant Phone Number
Applicant Social Security Number	Applicant DentalBlue Member ID Number (if known)

Section 1: Reason Continuation Elected (qualifying event):

- ☐ End of employment – enter employment end date: ______________________________
- ☐ Retirement (indefinite continuation) – enter retirement date: _______________________
- ☐ Divorce/end of domestic partnership – enter event date: __________________________
- ☐ Dependent no longer eligible
- ☐ Other (explain): ____

Section 2: Coverage to Be Continued (check one below)

- ☐ Employee Only
- ☐ Employee + 1 Dependent
- ☐ Employee + 2 or more Dependents
- ☐ Single Dependent
- ☐ 2 or more Dependents
- ☐ 3 or more Dependents

Complete the following information **ONLY** for individuals covered under the policy you plan to continue

Last Name	First Name	Birth Date	Gender	Relationship to Employee
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

For employees who were involuntarily terminated from employment between September 1, 2008 and December 31, 2009 ONLY

You may be eligible for up to nine months of COBRA premium assistance. If you are eligible for COBRA premium assistance, you also have the right to elect and continue a lower cost DentalBlue plan. If you elect coverage under the Supplemental Plan, you must carry Preventative and Diagnostic dental insurance through another plan. If you do not, you are restricted to the DentaCare HMO or Preferred PPO Plan.

Select the one plan you would like to continue: ☐ DentaCare HMO ☐ Preferred PPO ☐ Supplemental Plan

Section 3: Signature of Applicant - date and sign continuation form below:

Date (Mo/Day/Yr)	Applicant Signature:

(over for payment and application submission information)

Information and Instructions

If the person selecting group continuation coverage is not the group subscriber (the employee), or you are changing your plan or coverage level, a signed application must be included with this form. The application is located online at: http://www.bussvc.wisc.edu/ecbs/den-DentalApplication.pdf or you may contact your employer's benefits office for a paper application.

In order to continue coverage, you must submit this form and application, if applicable, within 60 days of the date on the enclosed notice or within 60 days of your coverage end date, whichever is later. Coverage may be continued for up to 36 months for all continuants except terminating employees who may continue coverage for 18 months and retirees who may continue coverage indefinitely.

Do not include any money with this application. Anthem DentalBlue will bill you directly for the first three months of coverage.

Send completed form(s) to:

If you did not involuntarily terminate employment between September 1, 2008 and December 31, 2009 and/or you are not eligible for COBRA premium assistance, send completed form(s) to: Anthem DentalBlue Dental Plan 4361 Irwin Simpson Road Mason, OH 45040	**If you involuntarily terminate employment** between September 1, 2008 and December 31, 2009 and you are applying for COBRA premium assistance, send completed form(s) to: Your employer's benefits office Contact information listed on enclosed letter

For Employer Use Only			
The individual(s) losing coverage ☐ is / ☐ is not eligible to continue coverage. If not eligible, it is due to: ☐ Failure to notify the employer within 60 days of loss of eligibility ☐ Other (explain):			
Extension of group coverage is in compliance with: ☐ COBRA ☐ Retiree Continuation ☐ Domestic Partner Continuation			
Group Premium Paid Through:		Group Number (check one): ☐ 83445 or ☐ 93881	
Date Received:	Received By:	Eligible for Premium Assistance: ☐ Yes ☐ No	Date sent to Anthem via fax: