

EXECUTIVE DENTAL & VISION

The Dental Plan Everyone Is Smiling About

Underwritten By



Co-Administered By



225 Wireless Boulevard, 2nd Floor, Hauppauge, NY 11788
Phone: (631) 951-9200 Fax: (631) 951-9623

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 \$ _____ 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.