

# Extended Dental Insurance COBRA

If you feel you have received this or another enclosed form in error, please call Employee Benefits at (706) 542-2222.

To be eligible for COBRA, you must have been an active participant in the plan prior to the qualifying event.

**I request:**

Continuation of my dental insurance

**EMPLOYEE**

• Benefits use only •

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Are you or your dependents covered under any other group/employer dental insurance program?

Yes  No

If yes, you are not eligible for UGA COBRA dental insurance. No need to submit this form. If no, complete the form and submit as indicated below.

APPLICANT'S NAME Last	First	MI	Daytime phone (include area code) <b>**REQUIRED**</b>
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BILLING ADDRESS (Include city, state, zip)

Present University System of Georgia dental insurance contract number	Email address	Date of last payroll deduction for dental insurance
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DATE OF BIRTH Mo. Day Year	Qualifying event <input type="checkbox"/> Terminated employment <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Transferred to ineligible position	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(ed) <input type="checkbox"/> Separated	<b>Coverage desired</b> <input type="checkbox"/> Applicant only <input type="checkbox"/> Applicant + child <input type="checkbox"/> Applicant + spouse <input type="checkbox"/> Family
DATE OF QUALIFYING EVENT Mo. Day Year				

\_\_\_\_\_  
Applicant signature

\_\_\_\_\_  
Date signed

**Complete & return this form to:**  
Employee Benefits  
Human Resources Bldg.  
215 South Jackson Street  
Athens, GA 30602-4133

**✓ Dependents are eligible for COBRA *only* if they were covered the day prior to the qualifying event (death, termination of employment, etc.)**

List **all** eligible individuals you wish to cover.

	Last name	First name	Relationship	Gender	Birthdate		
					Month	Day	Year
2.			<input type="checkbox"/> SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
<b>Children</b>							
			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
3.							
4.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
5.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
6.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
7.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

Information regarding the University System of Georgia dental plan benefits is available at:  
<http://www.usg.edu/employment/benefits/dental/>

\*Complete an "Application for Unmarried Dependent Student" form for children over age 19, available at: <http://www.busfin.uga.edu/benefits/ben2.html>

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[http://www.usg.edu/hr/benefits/dental\\_insurance](http://www.usg.edu/hr/benefits/dental_insurance)