

DENTAL CONTINUATION FORM

NOTIFICATION OF RIGHT TO CONTINUE DENTAL BENEFITS

THIS FORM MUST BE RETURNED TO ACCE BENEFITS SERVICES WITHIN 60 DAYS OF TERMINATION DATE

Employee Termination Date: _____ Employee terminations are always effective on the last day of the month

1. EMPLOYER INFORMATION

Employer Name _____

2. EMPLOYEE INFORMATION Please write legibly

Last Name _____ First Name _____ MI _____

Home Address _____ City, State _____ Zip _____

Work Email _____ Employee Title _____

Social Security # _____

3. COVERAGE/BENEFITS AFFECTED

Policy Holder Name: ACCE Policy Trust Group Number: 3082544

I have been informed of my option to continue the dental benefits for myself and/or my dependents, if any, for 18 months and I have chosen to:

- Elect to continue with my employer's dental benefits by paying the premium required and providing my employer with the information necessary to continue my coverage.
- Elect not to continue with my employer's dental benefits.

I understand that coverage will cease when I, my spouse and/or my dependent become(s) enrolled in another plan or when the dental plan sponsored through my former employer terminates. I understand failure to remit payment to my former employer by the due date or within 30 days of the due date will result in cancellation of coverage with no reinstatement allowed. I understand that in order to continue these dental benefits, the payment which I must remit monthly to my former employer is determined as follows:

Employee - \$44.19 Employee + Child(ren) - \$77.51 Employee + Spouse - \$91.61 Full Family - \$125.93

Rates are subject to change as a result of plan revisions.

My spouse and dependents, if any, are eligible to continue their dental insurance for 36 months upon the occurrence of the following events:

- Failure to continue to qualify as a dependent
- Upon my death
- When my spouse becomes legally separated or divorced from me
- When I become eligible for Medicare

As the spouse and/or dependent of _____, I elect to continue the group dental benefits by paying the premium required and providing the information necessary to continue the coverage.

As the spouse and/or dependent of _____, I elect not to continue with the group dental benefits.

4. SIGNATURES This form cannot be processed without both signatures

Employee Signature _____ Date _____

Employer Signature/Title _____ Date _____

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Scan and email to: accebenefitsteam@acce.org