

Election Form for Continuation Coverage Available Under Federal Law (COBRA)

Return this signed form to _____ . Be sure to complete **ALL** requested information.
(Company Name)

Employee Information (always complete this section)

Name _____ Social Security No. _____

I **Do** elect to continue coverage provided under the Group Dental Plan. I understand I am responsible for paying the premium by the 1st of each month and providing _____ with all required information.
(Company Name)

Continue coverage for the following covered person checked below:

- | | | |
|---|---|---|
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee and Spouse | <input type="checkbox"/> Employee, Spouse, and Child(ren) |
| <input type="checkbox"/> Spouse Only | <input type="checkbox"/> Spouse and Child(ren) Only | <input type="checkbox"/> Children Only |
| <input type="checkbox"/> Employee and Child(ren) Only | | |

List below names of all qualified beneficiaries to be covered:

Name (First, MI, Last)	Sex (M/F)	Date of Birth (Mo/Day/Year)	Social Security No.	Relation to Employee
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Amount Enclosed \$ _____ (see reverse side for your Total Monthly Cost). Be sure to include premium from the date continuation begins through the present month.

Make your check payable to _____ and deliver or mail it to the address shown on the reverse side.
(Company Name)

_____ Signature	_____ Date
_____ Your Address	_____ Customer Name (see reverse)
_____ City State Zip	_____ Employer Name (see reverse)

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166. Dental HMO plans in CA, FL and TX are available through a domestic company in the applicable state named SafeGuard Health Plans, Inc. The SafeGuard companies are part of the MetLife family of companies.

(Continued on following page)

REFUSAL STATEMENT

I hereby WAIVE my rights to continue Group Dental coverage under Federal Law (COBRA).

Signature of Employee Date Signature of Child (18 or Older) Date

Signature of Employee Date Signature of Child (18 or Older) Date

**Election Form for Continuation Coverage
Available Under Federal Law (COBRA)**

THIS SIDE FOR COMPLETION BY EMPLOYER OR PLAN ADMINISTRATOR

Employer Name _____

Attention _____

Address _____

Metropolitan Customer Number _____

Qualified Beneficiary Name _____

Date of Qualifying Event _____

Qualifying Event (check one):

18 Month Period Maximum – Employee Only

Termination of Employment

Reduction of Hours

36 Month Period Maximum - Spouse/Child(ren)

Divorce or Legal Separation

Death of Employee

Child Ceasing to be Dependent Under Plan

Employee Eligible for Medicare

Date Coverage Will End if Continuance is Not Elected: _____

Last Day to Elect Coverage: _____

COST

The premium includes both the employee and employer contributions under the plan, and is based on the current plan. Coverage and rates are both subject to change. Payment is to be sent to the employer at the above address by the 1st of each month.

Fill in below the total charge for which the qualified beneficiary is responsible. Medical coverage can be elected independently. Dental coverage can only be elected independently if you give an active employee the right to elect dental without medical.

Only those coverages that were in effect at the time the qualifying event occurred may be continued. And, only those persons actually insured on the date the qualifying event occurred can be continued. New eligible dependents may be added in accordance with the provisions of the group plan.

	Single Rate (One Qualified Beneficiary)	Multiple Rate (Two or More Qualified Beneficiaries)	Family Rate (Three or More Qualified Beneficiaries)
Dental	_____	_____	_____
Total Monthly Cost To Qualified Beneficiary	_____	_____	_____

Signature of Authorized Representative of Employer

Date Notice Provided to Qualified Beneficiary

**CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS**

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.

To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:

Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512

Please indicate to whom and where the translated document is to be sent.

Servicio de Idiomas Sin Costo. Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.

Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:

Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512

Por favor, indique a quién y a dónde debe enviarse el documento traducido.

NOMBRE _____
DIRECCIÓN _____

免費語言服務。 您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。為收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：

Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512

請指明經翻譯文件收件人的姓名及地址。

姓名 _____
地址 _____

Անվճար թարգմանչապան ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆոռնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាកម្មប្រដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntauv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau pab ntauv tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus Iv-saws-las ntauv 1-800-927-4357.

無料の通訳サービス。 通訳を通して日本語で文書を読み上げてもらえます。サービスの利用をご希望の方は、お手持ちのIDカードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357. **سرويس های ترجمه رایگان.** شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی، از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید. **بلا معاوضه مترجم دی خدمات مل سکدی اے۔** تسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گربوتو، دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔