REQUEST FOR CONSIDERATION AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

You may also want to read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA."

Send this form to:
Delta Dental of South Dakota
P.O. Box 1157
Pierre, SD 57501

PERSONAL INFORMATION

Employee name ____________________

Employee mailing address ____________________

City, State, and Zip ____________________

Employee phone number ____________________ Employee e-mail address ____________________

Employee dependents (please complete the form on the back side of this sheet, listing each dependent that is separately applying for the COBRA subsidy).

To qualify, you must be able to check "Yes" for all statements below.

1. The loss of employment was involuntary. ☐ Yes ☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009. ☐ Yes ☐ No
3. I elected (or am electing) continuation coverage. ☐ Yes ☐ No
4. I am eligible for other group dental plan coverage (or I was eligible for other group dental plan coverage during the period for which I am claiming a reduced premium). ☐ Eligible ☐ Not Eligible

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature ____________________ Date ____________________

Type or print name ____________________ Relationship to employee ____________________

FOR DELTA DENTAL USE ONLY

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #5 below)
Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. The loss of employment was voluntary. ☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009. ☐
3. Individual did not elect continuation coverage. ☐
4. Individual eligible for other dental plan coverage. ☐
5. Other (please explain) ☐

Signature of party responsible for continuation coverage administration for the Plan

Signature ____________________ Date ____________________

Type or print name ____________________

Phone number ____________________ E-mail address ____________________

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.) If more lines are needed, please attach additional information on a separate sheet of paper.

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. ____

1. I elected (or am electing) continuation coverage.	☐ Yes☐ No
2. I am eligible for other group dental plan coverage.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → ____________________ Date → ____________

Type or print name → ____________________ Relationship to employee → ____________

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. ____

1. I elected (or am electing) continuation coverage.	☐ Yes☐ No
2. I am eligible for other group dental plan coverage.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → ____________________ Date → ____________

Type or print name → ____________________ Relationship to employee → ____________

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. ____

1. I elected (or am electing) continuation coverage.	☐ Yes☐ No
2. I am eligible for other group dental plan coverage.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → ____________________ Date → ____________

Type or print name → ____________________ Relationship to employee → ____________

Name Date of Birth Relationship to Employee SSN (or other identifier)

d. ____

1. I elected (or am electing) continuation coverage.	☐ Yes☐ No
2. I am eligible for other group dental plan coverage.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → ____________________ Date → ____________

Type or print name → ____________________ Relationship to employee → ____________

DELTA DENTAL

Use this form to notify your issuer that you are eligible for other group dental plan coverage.

Delta Dental of South Dakota	**Participant Notification**	Plan Mailing Address P.O. Box 1157 Pierre, SD 57501

PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group dental plan. If any dependents are also eligible, include their names below. Insert date you became eligible_______________________	

IMPORTANT

If you fail to notify your issuer of becoming eligible for other group dental plan coverage AND continue to pay reduced continuation coverage premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → ____ Date → ____________________

Type or print name → ____

If you are eligible for coverage under another group dental plan and that plan covers dependents you must also list their names here:

________________________________ ________________________________

________________________________ ________________________________

Delta Dental of South Dakota
DENTAL ACCIDENT PLAN

24 hour coverage that pays in full, the maximum plan allowance for a covered benefit, up to $2,000.00 per accident at a cost everyone can afford.

Individual Plan	**Family Plan**
$5.00/person for a full year	$18.00 for a full year*

***Family Plan** covers head of household, spouse, and all dependent unmarried children up to their 19th birthday or to their 23rd birthday if enrolled as a full-time student.

DELTA DENTAL ACCIDENT PLAN. . . .

Comprehensive dental accident protection at a low cost

Dental Care Benefits

Payment of maximum plan allowance is made for treatment resulting from a dental accident which occurs during the period covered. Benefits include examination, diagnosis, dental x-rays, oral surgery, crowns, bridges and dentures.

Period Covered

Twenty-four hours per day, seven days each week for one full year.

Activities Covered

Accidents resulting from all activities are covered – including athletics, both on and off school grounds.

Additional Information

Contact: Delta Dental of South Dakota — 1-800-627-3961
PO Box 1157
Pierre SD 57501

DENTAL ACCIDENT BENEFIT AGREEMENT

Delta Dental of South Dakota
PO Box 1157
Pierre SD 57501
1-800-627-3961

EFFECTIVE DATE

This agreement is effective the first day of the month after the application form and premium are received by Delta Dental of South Dakota (DDSD). **Coverage will be in force for one year.**

ELIGIBILITY

Any person may enroll for Individual Plan Coverage regardless of age as long as the individual premium is paid per person.

The family plan covers head of household, spouse and all **dependent** unmarried children to their 19th birthday or to their 23rd birthday if enrolled as a full-time student.

COVERED AMOUNTS

DDSD will pay in full, the maximum plan allowance for a covered benefit. Only treatment rendered by a licensed dentist qualifies for payment. No benefits will be provided for hospital expenses, the services of a physician, or for any other ancillary services or care (including drug prescriptions). **There is a $2,000 maximum benefit per covered accident (of which a maximum of $1,000 can be for Prosthetics).** Predetermination of benefits is requested on all cases except emergency treatment.

COVERED BENEFITS

The following benefits are provided by this Agreement for treatment of accidental dental injury sustained by the enrollee(s) named on the application. Payment for dental care rendered by a licensed dentist, providing first treatment is administered within 30 days of the date of the accident, shall include:

1. Examination and diagnosis of injury
2. Dental x-rays
3. Fillings
4. Oral Surgery
5. Endodontics
6. Treatment of Infection
7. Pulpotomy
8. Permanent Crowns
9. And up to $1,000 for Prosthetics (dentures and bridges)

DDSD will pay benefits for the replacement of a missing tooth only once. The cost of temporary appliances will be deducted from the cost of permanent treatment. Additions to existing prosthetics will be paid as a percentage of the injured tooth to existing appliance.