The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765
www.LincolnFinancial.com

Please fax to (877) 573-6177
Total Pages Faxed ___________

DENTAL COBRA ELECTION FORM

Group Name:____ Group #:_________________________________

I, ____ , choose to continue group Dental coverage for myself and/or family members
(name of employee or spouse)
that are qualified dependents as listed below:

Qualified Dependent Name	Social Security #	Relationship To Employee
______________________________	____________________	______________________________
______________________________	____________________	______________________________
______________________________	____________________	______________________________
______________________________	____________________	______________________________
______________________________	____________________	______________________________
______________________________	____________________	______________________________

Employee's Social Security Number: ________________________________

Please indicate applicable Qualifying Event(s) and dates:		Date of Qualifying Event	Date of Coverage Loss
☐ Employee's termination of employment	☐ Employee's hours reduction	_____________	______________
☐ Employee's death	☐ Employee's Medicare entitlement	_____________	______________
☐ Divorce or legal separation		_____________	______________
☐ Child's loss of dependent status - Reason ______________________________ Examples: Reached age limit, married, no longer full-time student or financially dependent.		_____________	______________
☐ Employer's filing Chapter 11 bankruptcy and terminating or reducing retiree dental coverage.		_____________	______________

To continue Dental Insurance, you must complete this election form within 60 days from the latest of:

a) the date of the Qualifying Event;
b) the date of the loss of coverage; or
c) the date the Employer sends notice of the right to continue.
(Date notification was received:_____ /_____ /_____)

If the Qualifying Event was the Employee's termination of employment or hours reduction, a family member determined by the Social Security Administration to be totally disabled within 60 days after that event may be entitled to 29 months' continued coverage.

Name(s) of any totally disabled family member(s): ____

The Social Security Administration's determination letter: ☐ is attached.
☐ will be sent to The Lincoln National Life Insurance Company within 60 days after such determination is made.

(OVER)

Each monthly payment after the first payment is due the first day of the insurance month, but must be received by the Employer no later than the 31st day of the insurance month for which it is due. Failure to make appropriate payment by that day will result in termination of coverage. There may not be re-enrollment under the Plan.

I understand the eligibility requirements for Dental coverage and declare that I and the dependents listed above are currently insured under the Plan. I understand that future premiums must be paid in advance in order for coverage to continue. I certify that the above information is correct. I understand and agree to abide by all of the above statements and Plan requirements.

______________________________	______________________________
Date of Election	Signature of Employee or Spouse
______________________________	______________________________
Signature of Policyholder / Employer	Date