MetLife

Election form for continuation coverage available under federal law *(COBRA)*

Things to know before you begin

- 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.

Be sure to complete **ALL** requested information.

SECTION 1: Employee information *(always complete this section)*

First name	Middle name	Last name

Your address - Street	City	State	ZIP code

Social Security number

_____

SECTION 2: Election statement

☐ I **Do** elect to continue coverage provided under the ☐ Group Dental and/or ☐ Group Vision.

I understand I am responsible for paying the premium by the 1st of each month and providing _____ *(Company name)* with all required information.

Continue coverage for the following covered person checked below:

☐ Employee only ☐ Employee and Spouse ☐ Employee, Spouse, and Child(ren)

☐ Spouse only ☐ Spouse and Child(ren) only ☐ Child(ren) only

☐ Employee and Child(ren) only

List below names of all qualified beneficiaries to be covered:

First name	Middle name	Last name

Sex	Date of birth *(mm/dd/yyyy)*	Social Security number	Relation to employee
☐ Male ☐ Female			

First name	Middle name	Last name

Sex	Date of birth *(mm/dd/yyyy)*	Social Security number	Relation to employee
☐ Male ☐ Female			

First name	Middle name	Last name

Sex	Date of birth *(mm/dd/yyyy)*	Social Security number	Relation to employee
☐ Male ☐ Female			

First name	Middle name	Last name

Sex ☐ Male ☐ Female	Date of birth *(mm/dd/yyyy)*	Social Security number	Relation to employee

Be sure to include premium from the date continuation begins through the present month.*(see page 3 for your Total Monthly Cost)*

Amount enclosed

_____

Make your check payable to _____ *(Company name)*

and deliver or mail it to the address shown in Section 5.

Sign Here	Signature	Date *(mm/dd/yyyy)*

SECTION 3: Refusal statement

☐ I hereby WAIVE my rights to continue ☐ Group Dental and/or ☐ Group Vision coverage under Federal Law *(COBRA)*

Sign Here	Signature of of Employee *(for Group Dental)*	Date *(mm/dd/yyyy)*
Sign Here	Signature of Child *(18 or older)*	Date *(mm/dd/yyyy)*
Sign Here	Signature of Employee *(for Group Vision)*	Date *(mm/dd/yyyy)*
Sign Here	Signature of of Child *(18 or older)*	Date *(mm/dd/yyyy)*

SECTION 4: How to submit this form

Return this signed form to _____

SECTION 5: For completion by Employer or Plan administrator

Employer name	Attn:

Employer address	City	State	ZIP code

Date of qualifying event *(mm/dd/yyyy)*	Customer number

Qualified beneficiary – First name	Middle name	Last name

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 *(mm/dd/yyyy)*	Last day to elect coverage *(mm/dd/yyyy)*

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. Subject to the terms of the plan, medical, dental and vision coverage may each be elected independently.

Only those coverages that were in effect at the time the qualifying event occurred can be continued. And, only those persons actually insured on the date the qualifying even 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			
Vision			
Total cost to qualified Beneficiary			

Sign Here

Signature of authorized Representative of employer	Date notice provided to qualified Beneficiary *(mm/dd/yyyy)*

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 թարգմանչական 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 Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាបកប្រែដោយឥតគិតថ្លៃ ។ 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 ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm 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 ntawm 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うことができます。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.

سرویس 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 معاوضہ مترجم دی خدمات مل سکدی اے۔ تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڑھ سکدا اوے۔ 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۔