MT. DIABLO UNIFIED SCHOOL DISTRICT
Human Resources
Benefits Office
(925) 682-8000 x 4152
benefits@mdusd.org

Effective Date: _____

Termination Date: _____

Employee and Dependents

Retiree Dental
COBRA Continuation Election

If you wish to purchase continued Delta Dental coverage under the Consolidated Omnibus Reconciliation Act (COBRA), please complete this form and return it to the Mt. Diablo Unified School District ("District") Benefits Office **no later than 60 days from the date your coverage ends.** Failure to return this form within the specified period of time will be considered an election against coverage. If you elect against (or are considered to have elected against) COBRA coverage for you and/or your dependents, all rights to COBRA coverage shall be forfeited. Complete the COBRA Payment Agreement on the reverse side and follow the instructions for payments.

Employee Name (Please Print)		Employee ID and/or Social Security Number
Employee Street Address		❑ Male **OR** ❑ Female
Employee City and Zip Code		Employee Date of Birth
Employee **Cell** Phone Number	Employee **Home** Phone Number	Employee Email Address

I elect to enroll myself and eligible dependents listed below in COBRA. Please check ALL boxes that apply and note length of COBRA coverage:

❑ Separation of Employment-Retirement (18 months)
❑ I am 65 (Medicare Age) or Older (36 months even if reason is checked above)

❑ Delta Dental 1-Party **$49.95** – monthly rate
❑ Delta Dental 2-Party **$99.90** – monthly rate
❑ Delta Dental Family (3+) **$154.55** – monthly rate

If you are continuing coverage for any dependents, list their name(s), relationship and date of birth.

Dependent Name	Relationship ❑Child under Age 26 ❑Spouse ❑Domestic Partner	Date of Birth
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Are you enrolled in Medicare?
❑ No ❑ Yes, I was entitled to Medicare as of _____ (1st day of the month you turned 65)

Are you currently disabled according to the Social Security Administration (*skip this section, sign, and date below if this is not applicable to you*). If you have been determined by the Social Security Administration to have been disabled on the date of termination of benefits, you may be eligible to extend your COBRA benefits for a maximum of 29 months instead of 18 months. ***If your loss of coverage already allows you to receive 36 months of COBRA benefits,*** that would be the maximum so ***do not complete this section.*** You must notify the Benefits office within the first 60 days of COBRA coverage if you are determined disabled by the Social Security Administration.

❑ Yes, I am disabled. ❑ No, I have not yet been determined disabled by the Social Security Administration but in the process.

If in the process of Social Security determination of disability, I understand I must notify the District Benefits office within 60 days of the Social Security determination (while enrolled in COBRA) to extend my COBRA up to a maximum of 29 months.

Applicant's Signature: _____ *Date:* _____

COBRA PAYMENT AGREEMENT for DENTAL COVERAGE

Copies Sent To:

☐ Fiscal _____
☐ Employee_____

I hereby request that the Mt. Diablo Unified School District make premium payments on my behalf for my group insurance coverage for Dental benefits as requested on the reverse side of this form. I understand that in order to continue my coverage, I must fulfill the following conditions:

1. Checks are made **payable to:** **MDUSD**

2. Checks are **mailed to:** Mt. Diablo Unified School District
Fiscal Services Department
1936 Carlotta Drive
Concord, CA 94519-1397

Your initial payment with the enrollment form is mailed/delivered to the Benefits Office with both sides of this form completed. Once billing begins from the Fiscal Services Department, all premiums will then be mailed to the Fiscal Services Department.

3. All premiums must be paid one (1) month in advance. If payment is not received by Fiscal Services by the due date, coverage will be canceled. You may pay several months in advance. Be sure to include a separate note or a note on your check if you are paying for more than one (1) month.

4. Premiums **must be received** by Fiscal Services **no later than the 10th of the month** preceding the period in which coverage is to continue (for example, for August coverage, payment must be received in Fiscal Services by July 10th).

Fill out name/address where invoices are to be mailed **(please print):**

NAME: _____

ADDRESS: _____

_____

PHONE/EMAIL: _____

I understand that my Dental coverage will be canceled if Fiscal Services does not receive payment by the 10th of the month prior to coverage continuing. **I understand coverage will not be reinstated once it has been canceled due to nonpayment**.

_____ _____
Signature ***Date***

Rev 08-01-2025