



### UNIVERSITY OF WISCONSIN SYSTEM DENTALBLUE CONTINUATION FORM

Employee Name (Last, First, Middle)	Applicant Name (if different from employee name)
Applicant Address (Street, City, State, Zip)	Applicant Phone Number
Applicant Social Security Number	Applicant DentalBlue Member ID Number (if known)

#### Section 1: Reason Continuation Elected (qualifying event)

- End of employment – enter employment end date: \_\_\_\_\_
- Retirement (indefinite continuation) – enter retirement date: \_\_\_\_\_
- Divorce/end of domestic partnership\* – enter event date: \_\_\_\_\_
- Dependent no longer eligible\* - enter event date: \_\_\_\_\_
- Other\* (explain): \_\_\_\_\_

\*If the person selecting continuation is not the subscriber, include a group DentalBlue application with this form.

#### Section 2: Coverage to Be Continued (check one below)

Select the one plan you would like to continue:  Supplemental Plan\*  Preferred PPO  DentaCare HMO

Select the coverage level:  Single coverage  Two-Person coverage  Family coverage (3 or more insured)

Complete the following information **ONLY** for individuals covered under this policy you plan to continue

Last Name	First Name	Birth Date (mo/day/yr)	Gender	Relationship to Employee
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

\*NOTE: You are only eligible to continue the plan you are currently enrolled in until Open Enrollment. However, if you carry the Supplemental Plan, you must carry a minimum of Preventive and Diagnostic dental coverage through another plan. If you do not have this primary dental coverage, then you must elect to continue the HMO or PPO plan.

#### Section 3: Signature of Applicant – date and sign continuation form below:

Date (Mo/Day/Yr)	Applicant Signature:
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Do not include any money with this application. Anthem DentalBlue will bill you directly on a monthly or annual basis, depending on your status as a retiree or COBRA continuant. Send this form (and application if appropriate) to:

**Anthem DentalBlue Dental Plan**  
**4361 Irwin Simpson Road**  
**Mason, OH 45040**

<b>For Employer Use Only – Complete Before Issuing Form to Employee</b>	
The individual(s) losing coverage <input type="checkbox"/> is / <input type="checkbox"/> is not eligible to continue coverage. If not eligible, it is due to: <input type="checkbox"/> Failure to notify the employer within 60 days of loss of eligibility <input type="checkbox"/> Other (explain):	
Extension of group coverage is in compliance with: <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree Continuation <input type="checkbox"/> Domestic Partner Continuation	
Group Premium Paid Through:	Group Number (check one): <input type="checkbox"/> 83445 or <input type="checkbox"/> 93881
Monthly Premium Due for Continued Coverage: \$ _____ <b>Note:</b> If the individual changes the coverage level when electing to continue coverage, the monthly premium may be different than the amount shown here.	