Dental Blue Continuation Form
State of Wisconsin

Anthem BlueCross BlueShield

SECTION 1: EMPLOYEE/APPLICANT INFORMATION

Employee name	Applicant last name (if different from employee)		
Applicant street address	City	State	ZIP code
Applicant phone no.	Applicant Social Security no.	Applicant Dental Blue member ID no. (if known)	

SECTION 2: 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 electing continuation is not the subscriber, include a group Dental Blue Application with this form.

SECTION 3: COVERAGE TO BE CONTINUED

Check one: ☐ Single coverage ☐ Two-person coverage ☐ Family coverage (3 or more insured)

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

Complete the following information ONLY for individuals who are currently covered under this policy and who you will continue to cover.

Last name	First name	Birthdate	Gender	Relationship
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	

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 Preventative 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 the PPO plan.

SECTION 4: SIGNATURE OF APPLICANT — Date and sign continuation form below

Applicant signature **X**	Date

Do not include any money with this application. Anthem Dental Blue will bill you directly on a monthly or quarterly basis, depending on your status as a COBRA continuant or retiree. Send this form (and application if appropriate) to:

Anthem Dental Blue
13550 Triton Park Blvd
Louisville, KY 40223-4197

FOR EMPLOYER USE ONLY

The individual(s) losing coverage is / is not eligible to continue coverage. If not eligible, it is because of:
☐ Failure to notify the employer within 60 days of loss of eligibility
☐ Other (explain): _____

Extension of group coverage is in compliance with: ☐ COBRA ☐ Retiree Continuation ☐ Domestic Partner Continuation

Group premium paid through	Group no. (check one) ☐ 83445 ☐ 93881	Monthly premium amount due for continued coverage: $_____

Notes: If you change your coverage level when you continue coverage, your premium may be different than the amount shown here. Coverage level can only be decreased at time of Continuation without a qualifying event, or until Open Enrollment.

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