SOUTH DAKOTA
state employee
benefits program
learn. act. thrive.

Application to Continue Benefits--COBRA

South Dakota State Employee Benefit Program
500 East Capitol Avenue Pierre, SD 57501-5070
Phone: 605.773.3148 Fax: 605.773.6840
http://benefits.sd.gov

Name: ____ SSN or Insurance ID: __________________________
Last First MI

Mailing Address: ____
Street City State Zip Code

Date of Birth: ____/_____/_____ Phone:_____________________Email:___________________________________

1) I am: ☐ a former employee ☐ a participating family member
If you are a participating family member, please list current or former employee information:

Name: _______________________________________Emp. Soc. Sec. No. _________-______-_________

2) ☐ **I DO** elect continuation coverage.
You must also complete the Direct Payment Plan form and attach a voided check with your application.

☐ **I DO NOT** elect continuation coverage. (Please complete the information above, sign and return this form.)

3) Participant and/or dependent information for each person who will be continuing coverage:

Name	Birth Date	Soc. Sec. No.	Which Plan(s)?

4) I request continuation coverage for the following plans: (Check all that apply.)

☐ Health Plan
☐ Low Deductible Health Plan ($1,000)
☐ High Deductible Health Plan ($2,000 | $4,000)

☐ Medical Flexible Spending Account
☐ Dental Plan
☐ Base Plan
☐ Enhanced Plan
☐ Vision Plan

5) Non-tobacco User or Tobacco User?

☐ I am **not** a tobacco user
☐ I am a tobacco user

☐ My covered spouse is **not** a tobacco user
☐ My covered spouse is a tobacco user

6) Which qualifying event(s) make you eligible for continuation coverage?

☐ Employee Termination
☐ Employee Death
☐ Reduction of Employee's Hours
☐ Child is Ineligible to be Covered as a Dependent

☐ Divorce or Legal Separation
☐ Receiving Coverage Under Medicare
☐ Disabled Employee
☐ Retired Employee*
* Watch for Retiree Enrollment forms coming soon.

I represent that the foregoing information is, to the best of my knowledge and belief, accurate. I agree that to retain coverage, I (we) must abide by the Plan's provisions.

____ ______________________________

Applicant Signature **Date Signed**

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN

FY19 PLAN YEAR

July 1, 2018 – June 30, 2019

Starting July 1, 2018, the following monthly premium rates will apply for COBRA Health Plan members:		
Coverage Level	Low Deductible Plan ($1,000)	High Deductible Plan ($2,000/$4,000)
Participant Only	$602.39	$564.64
Participant + Spouse	$1,301.01	$1,219.06
Participant + Child(ren)	$925.47	$869.30
Participant + Family	$1,623.46	$1,523.08
NOTE: Contributions for employee and spouse coverage will increase $60.00 per person per month if you and/or your covered spouse use tobacco.		

DENTAL		
	Base Dental Plan Premiums	Enhanced Dental Plan Premiums
Participant Only	$33.05	$53.39
Participant + Spouse	$65.99	$106.59
Participant + Child(ren)	$72.24	$108.69
Participant + Family	$105.18	$161.91

VISION	
Coverage Level	Monthly Premiums
Participant Only	$7.22
Participant + Spouse	$14.46
Participant + Child(ren)	$12.24
Participant + Family	$20.20