Delta Dental of South Dakota
PO Box 1157 Pierre, SD 57501
1-800-627-3961
Fax (605) 224-0909
www.deltadentalsd.com

Notice of Qualifying Event

(to be completed by the employer)

Completion of this form authorizes Delta Dental and/or DeltaVision to send a Notice of Rights for COBRA coverage

Group name: _____

Dental Group number: _____ Vision Group number: _____

Employee name: _____ SSN or Alt ID#: _____

Employee address: _____

_____

Last day of coverage: _____ COBRA start date: _____

Date of qualifying event: _____ ☐ Dental ☐ Vision

Check the qualifying event for the employee listed above:

- ☐ End of employment
- ☐ Reduction of hours
- ☐ Retirement
- ☐ Military leave
- ☐ Death of covered employee
- ☐ Medicare eligible
- ☐ Divorce or legal separation (list name of spouse and children losing coverage)
- ☐ Child's loss of dependent status (list child's name below)

Name of spouse or child: _____

Address (if different): _____

_____

Completed by: _____ Date: _____

Phone: _____

Please email this form to: eligibility@deltadentalsd.com