Extension of Medical and Dental Coverage

(NOT TO BE USED BY CANONICALLY RESIDENT CLERGY
PLEASE CALL THE BENEFITS OFFICE FOR CLERGY FORMS & INFORMATION)

The Diocese of California does not have COBRA obligation under federal laws and regulations. However, we have elected to provide a Continuation of Coverage option for our employees and their eligible dependents. The following outlines the basic provisions of this policy.

1. Medical Continuation does not apply to canonically resident clergy. Cleric should contact Sarah Crawford for information & forms to purchase medical, dental, life & EAP coverage.

2. Extension of Medical Benefits (for up to 36 mo) will be provided through The Episcopal Church Medical Trust. ECMT will send instruction directly to you. If you have questions on extension of medical benefits please call ECMT client services 800-480-9967.

3. Extension of Cigna dental coverage may be continued for up to 18 mo through the Diocese of California. Cigna dental coverage must be in place at the time of the termination.

4. The terminated employee pays the cost of the coverage effective the first of the month following date of termination. For example: if your employment ends on April 12 your employer will continue your coverage until April 30, then you will assume responsibility for coverage effective May 1.

5. You must complete the Dental Extension of Benefits forms within 30 days of your termination date. Failure to comply with this provision will end your eligibility for continuation of Cigna Dental coverage.

6. If premiums are not paid within 30 days of their due date, coverage will be terminated retroactive to the last day of the period for which premiums have been received.

7. You may cease coverage by notifying the diocesan administrator in writing of your decision. Notice must be in writing. Coverage will be terminated on the last day of the month requested.

8. All correspondence about the continuation of Cigna dental policy must be addressed to:

   Diocese of California Benefits Administrator
   1055 Taylor Street
   San Francisco, CA 94108
   Email: sarahc@diocal.org

9. For questions, please call, fax or email:
   Sarah Crawford, Benefits Coordinator
   Ph: 415-869-7805
   FAX 415-673-4863
   Email sarahc@diocal.org
DENTAL CONTINUATION ELECTION FORM
FOR LAY EMPLOYEES ONLY

(NOT TO BE USED BY CANONICALLY RESIDENT CLERGY
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Notice Date: ____________________________  Prepared By: ____________________________

Former Employer (entity name & city) : ______________________________________________

Termination Date (continuation of coverage begins on the 1st of month following term date): ____________________________

Dear (employee name) __________________________________________:

Former employees are eligible to continue their current medical / dental benefits at their own expense. ECMT will provide information & instruction regarding your extension of medical. If you wish to continue dental insurance please read on.

To continue Cigna dental coverage, you must respond with payment for your first month’s insurance premiums within 30 days from your termination date. You will be billed for your monthly premiums thereafter. Your monthly payment is due by the first of each month, whether or not you receive a bill.

If you wish to continue dental coverage, please read the instructions (previous page) and the statement below, sign it, then send this letter and a check to cover one month’s premium payable to “The Diocese of California” attn: Benefit’s Office, 1055 Taylor Street, San Francisco, CA 94108.

I wish to continue Cigna dental coverage at my own expense, and have enclosed payment to cover the cost of my first month’s premiums. I understand that the Diocese must receive this notice and payment within 30 days of my termination date. I further understand that future payments will be due on the first of each calendar month.

Yes, I accept continued Cigna dental coverage and will submit payment each month:

Single $61.51  Dual $112.89  Family $165.82

Signed: __________________________________  Date: ____________________________
Name: ___________________________________  Social Security #: ____________________________
Address: __________________________________
City: ____________________________  State: __________ Zip: __________
Phone: ____________________________  Fax: ____________________________  Email: ____________________________