

## 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 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. Cigna dental coverage may be continued through the Diocese and this coverage must be in place at the time of the termination of your employment. Only those dependents covered at the time of termination may be covered under this policy.
4. Medical & Dental continuation coverage lasts for a maximum of 18 months.
5. **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.
6. You must complete the enrollment forms within 30 days of your termination date. Failure to comply with this provision will end your eligibility for continuation of coverage.
7. **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.**
8. 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.
9. 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](mailto:sarahc@diocal.org)

10. For questions, please call, fax or email Sarah Crawford, Benefits Coordinator  
Ph: 415-869-7805  
FAX 415-673-4863  
Email [sarahc@diocal.org](mailto:sarahc@diocal.org)

Benefits Office, Episcopal Diocese of California  
1055 Taylor St., SF, CA 94108  
Email: [sarahc@diocal.org](mailto:sarahc@diocal.org)  
Fax: 415-673-4863  
Phone: 415-869-7805  
Web: [www.diocal.org/employeebenefits](http://www.diocal.org/employeebenefits)

## DENTAL CONTINUATION ELECTION FORM – FOR LAY EMPLOYEES ONLY

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

Notice Date: \_\_\_\_\_ Prepared By: \_\_\_\_\_

Former Employer (entity name & city) : \_\_\_\_\_

Termination Date (continuation of coverage begins on the 1<sup>st</sup> of month following term date): \_\_\_\_\_

Dear (employee name) \_\_\_\_\_:

Former employees are eligible to continue their current medical / dental benefits at their own expense for up to 18 months. 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 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 to: The Diocese of California, Benefit's Office, 1055 Taylor Street, San Francisco, CA 94108.

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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.

I accept continued Dental Coverage:    Yes        No        Premium:    Single \$64.53    Dual \$118.86    Family \$173.98

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_