

COBRA Notification of Qualifying Event



Employer Information

Employer Name _____ Division/Location/Local _____
 Contact Person _____ Phone No. _____

Qualified Beneficiary Information

The qualified beneficiary is the person the letter is going too: Employee _____ Dependent _____
 If dependent, complete this section with the dependent's information i.e. The ex-spouse's in case of divorce or dependent child's if no longer being covered.

Last Name _____ First _____ Initial _____
 Participant ID _____ Date of birth _____
 Participant Address _____ City _____ State ____ Zip _____
 Marital Status Married ____ Single ____ Divorced ____ Gender Female ____ Male ____
 Qualifying Event Date _____ Insurance Termination Date _____
 Qualifying Event Code: _____

Please use the following codes: T = Termination, D = Death, L = Medical Leave, M = Medicare, R = Reduced Hours, S = Disability, V = Divorce, P = Dependent ceases to be covered, C = Loss of coverage/Laid off

Dependent Information

	Dependent Name	Relationship
Full Name _____		Spouse _____
Full Name _____		Child _____
Full Name _____		Child _____
Full Name _____		Child _____

Continuing Coverage Information

Benefit Type	Insurance Carrier	Check Level of coverage for the participant(s) Indicate number of students if more than 1			
		Single	Single + Children	Single+ Spouse	Family
Health					
Dental					
Vision					
Prescription					
FSA-Health Care Reimbursement		\$_____ per month		\$_____ per year	

Prepared by _____
 Printed name of preparer _____ Signature of preparer / Date _____

This form must be completed by a representative of the employer. Please fax or email this completed form within 30 days of the qualifying event.