

Notice of Qualifying Event for COBRA Coverage

Company Name: _____

Prepared By: _____

Information. on the Primary Qualified Beneficiary (PQB): In the event of an employee experiencing a Qualifying Event, the PQB is the employee. If the Qualifying Event and the loss of coverage occurs to a spouse or child, they are the PQB.

SSN: _____ PQB Name: _____

PQB Mailing

Address: _____
(address) (city) (state) (zip)

Phone: _____ E-mail: _____

Date of Birth: _____ Date of Hire: _____ Gender: Male Female

Marital Status Single Married Divorced Legal Separation

1st day of Insurance coverage: _____ Premium Paid Through Date: _____ Notified Carrier Date: _____

Date of the Qualifying Event: _____

Description of the Qualifying Event (check one only):

<input type="checkbox"/> Termination	<input type="checkbox"/> Loss of Coverage
<input type="checkbox"/> Reduction in hours	<input type="checkbox"/> Divorce or legal separation *
<input type="checkbox"/> Death of employee	<input type="checkbox"/> Loss of dependent status *.
<input type="checkbox"/> Employee's Medicare Entitlement	<input type="checkbox"/> Leave of Absence
<input type="checkbox"/> Social Security Disability (send SSA determination letter which needs to be submitted within 60 days from the date of the determination).	<input type="checkbox"/> Other * send documentation of event

List Coverage(s) Currently in effect:

What type of coverage did the employee have prior to the Qualifying Event?

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Children
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Family

Employee benefits prior to the Qualifying Event (Please check all that apply)
For example, Carrier Health Plan Name Blue Cross, PPO, HMO

<input type="checkbox"/> Medical <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other _____	<input type="checkbox"/> Dental <input type="checkbox"/> DMO <input type="checkbox"/> PPO <input type="checkbox"/> Other _____
<input type="checkbox"/> Vision _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Section 125 / Cafeteria Plan	

If the employee was enrolled in a Cafeteria Plan (Unreimbursed Medical or Dependent Care only) What was the monthly contribution? \$ _____

Family Members On COBRA - If they are not a Qualified Beneficiary, please make note.

First Name: <small>If last name is different, asterisk and indicate at bottom.</small>	SSN - if available	Spouse or Child	Gender: M or F	DOB:	Address, if different
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

* Last Name: _____

Comments/Notes: _____

