COBRA EVENT NOTIFICATION

Client: _____ **Location/Branch:** _____

1. Primary Qualified Beneficiary (PQB) Information:

PQB Name: _____ Employee Name: _____

Social Security #: ___–___–___ Birthdate: _____

Address: _____

City/State/Zip: _____

Phone: _____ Email: _____ Gender: _____

2. Dependent Information:
(If address is different from employee, attach a separate sheet with address. If spouse is currently enrolled under Spousal Continuation, notify our office.)

Name: _____ Social Security #: _____ DOB: _____

Relationship to PQB: _____ Gender: _____ Is the dependent a qualified beneficiary (Y/N)? ____

Name: _____ Social Security #: _____ DOB: _____

Relationship to PQB: _____ Gender: _____ Is the dependent a qualified beneficiary (Y/N)? ____

Name: _____ Social Security #: _____ DOB: _____

Relationship to PQB: _____ Gender: _____ Is the dependent a qualified beneficiary (Y/N)? ____

Name: _____ Social Security #: _____ DOB: _____

Relationship to PQB: _____ Gender: _____ Is the dependent a qualified beneficiary (Y/N)? ____

3. COBRA Qualifying Event Date: _____
(Each benefit may vary, please specify)

4. COBRA Start Date: _____
(Each benefit may vary, please specify)

5. Original Effective Date on the group health plan as/under the active employee: _____

6. Type of qualifying event (check one):

☐ Voluntary termination ☐ Involuntary termination ☐ Reduced hours ☐ Retirement ☐ Death
☐ Divorce/legal separation ☐ Child ceasing to be a dependent ☐ Other: _____

7. Indicate the plan the QB's are in enrolled in along with the respective coverage level.

Specify Plan for:	Specify Coverage Level for each plan:
Medical: _____	_____
Dental: _____	_____
Vision: _____	_____
Other (i.e. FSA, HRA): _____	_____

_____ _____
Signature **Date**

_____ _____
PRINT NAME **Title**