COBRA Qualifying Event Notification

(Fax completed form to 336-759-3999. Please Print!)

Company Name: _____

Employee Last Name: _____ First Name: _____ Middle Initial: _____

Employee Address: _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____ DOB: _____ Sex: ❑ M ❑ F

Employee SSN: _____ Hire Date: _____ Qualifying Event Date: _____

> **Participating Qualified Beneficiary – if COBRA qualifying event is for covered dependent only:**
>
> Last Name: _____ First Name: _____ Middle Initial: _____
>
> Qualified Beneficiary SSN: _____ DOB: _____ Sex: ❑ M ❑ F

COBRA Qualifying Event Causing Loss of Coverage *(Please check only one.)*

Continuation for 18 Months:
❑ Employee's termination of employment
    ❑ Involuntary termination
    ❑ Voluntary termination
❑ Employee's reduction of hours

Continuation for 29 Months:
❑ Employee's termination of employment due to disability
❑ Employee's reduction of hours due to disability

Continuation for 36 Months:
❑ Death of employee / retiree
❑ Divorce / legal separation
❑ Covered employee or retiree becomes entitled to Medicare. Dependents may elect continuance of identical coverage.
❑ Ineligibility of dependent child

Continuation Coverage - *Please complete all applicable fields in the following tables.*

	Health / Medical	Dental	Vision	FSA	HRA
Name of Plan[1]					
Type of Coverage[2]					
Benefit Term. Date[3]					
Last Payroll Date[4]	/////	/////	/////		

[1] If two or more plans of the same coverage are offered to the employee, please indicate which plan the employee has. For example: "Dental Plan A", "Dental Plan B", "Medical Basic", etc.
[2] For example: "Family", "Employee Only", "Employee+Child", etc.
[3] Specify last date covered as an employee.
[4] Specify date of final payroll withholdings.

Please provide date (mm/dd/yyyy) that continuous coverage began for each benefit, regardless of carrier changes.

	Name	Health	Dental	Vision	FSA	HRA
Employee						
Spouse					/////	/////
Child					/////	/////
Child					/////	/////
Child					/////	/////

Form prepared by: _____ Date: _____

Phone: (_____) _____ Email: _____

Comments: _____