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: ____________

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.*

	FSA	
Type of Coverage[2]		
Benefit Term. Date[3]		
Last Payroll Date[4]		

[2] For example: "Family", "Employee Only", "Employee+Child", etc.
[3] Specify last date covered as an employee.
[4] Specify date of final payroll withholdings.

Form prepared by: ____ Date: __________________________

Phone: (_________) ________________________________

Email: ____

Comments: ____

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