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: _____

SaversAdmin PAYROLL HR BENEFITS
635 W. Fourth Street, Suite 201 • Winston-Salem, NC 27101-2740
336.759.3888 local • 800.949.0311 toll-free • 336.759.3999 fax
www.saversadmin.com • cobra@saversadmin.com