

# COBRA Qualifying Event Notification

1-800-9898-PRO  
 1-248-543-2296 FAX  
 cobra@adminproadvantage.com

All items must be completed to properly process this request. COBRA regulations state that the administrator must be notified no later than 30 days of the qualifying event or loss of coverage.

<b>Employer / Division</b>	Date Sent	# Pages
Contact Person	Phone (       )	Ext

<b>Employee Name</b>	SS#	Gender	Birth Date
Address	City	State	Zip
			Phone (       )

If other than single coverage, please list names, social security numbers and birthdates for any other covered family members (if not living with employee, please indicate address in Notes section below)

Dependent Name	SS#	Birth Date	Relationship

## COBRA Event Information

<b>COBRA Event Date</b>	<b>Date Active Coverage Terminates</b>						
<b>Type of COBRA Event</b> (please check one) <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> <b>Involuntary Termination</b> (fired, layoff, reduction in workforce)</td> <td><input type="checkbox"/> <b>Death of Employee</b> (spouse &amp; dependent children only)</td> </tr> <tr> <td><input type="checkbox"/> <b>Voluntary Termination/Resignation/Retirement</b></td> <td><input type="checkbox"/> <b>Divorce or Legal Separation</b> (spouse &amp; dep children only)</td> </tr> <tr> <td><input type="checkbox"/> <b>Reduction of Hours</b> (full-time to part-time, unpaid leave of absence)</td> <td><input type="checkbox"/> <b>Loss of Dependent Status</b> (dependent children only)</td> </tr> </table>		<input type="checkbox"/> <b>Involuntary Termination</b> (fired, layoff, reduction in workforce)	<input type="checkbox"/> <b>Death of Employee</b> (spouse & dependent children only)	<input type="checkbox"/> <b>Voluntary Termination/Resignation/Retirement</b>	<input type="checkbox"/> <b>Divorce or Legal Separation</b> (spouse & dep children only)	<input type="checkbox"/> <b>Reduction of Hours</b> (full-time to part-time, unpaid leave of absence)	<input type="checkbox"/> <b>Loss of Dependent Status</b> (dependent children only)
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## COBRA Eligible Benefits

Please list all COBRA eligible benefits in which the employee is enrolled. These include medical reimbursement accounts, health, dental and vision plans.

Benefit	Carrier	Type (single, family, etc.)	Monthly Premium	Original Effective Date

Medical FSA?    Y or N  
 Annual Flex Election \$ \_\_\_\_\_ Contributions to Date \$ \_\_\_\_\_ Claims to Date \$ \_\_\_\_\_

Last payroll date deduction will be taken \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medical HRA?    Y or N

**NOTES:** use the notes area to indicate different address for spouse/dependents, special leave, FMLA employer premium amount, unusual circumstances, or indicate additional children \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>FOR EXISTING COBRA ENROLLEES - complete information below</b>	
Date Last Premium Paid: ____ / ____ / ____	Coverage Paid Through: ____ / ____ / ____
COBRA Notification Date: ____ / ____ / ____	Received Notification Date: ____ / ____ / ____