# *COBRA* Qualifying Event Notification Form for *COBRA* Continuation Coverage

**Notice Reporting Date:** _____

**Employer's Name:** _____

**Qualified Beneficiary Information**

**Name: Last** **First** **Middle** **Social Security Number**

_____

**Address: Street** **City** **State** **Zip Code**

_____

**Date of Birth:** / / **Martial Status:** ❒ **Single** ❒ **Married**

**No. of Dependent Children:** _____ **Date of Hire:** / /

**On** _____, **the above qualified beneficiary incurred the following "qualifying event" for purposes of COBRA continuation coverage:**

- ❒ **Involuntary Resignation**
- ❒ **Voluntary Resignation**
- ❒ **Reduction in Hours**
- ❒ **Discharge (Misconduct)**
- ❒ **Retirement**
- ❒ **Employee's Medicare Entitlement**
- ❒ **Start of bankruptcy proceeding**
- ❒ **Dependent Child has reached the age Maximum**
- ❒ **No longer a Full Time Student**
- ❒ **Former Spouse of an Employee**
- ❒ **Former Spouse of a Retiree**
- ❒ **Death of an Employee**
- ❒ **Death of a Retiree**
- ❒ **Surviving Spouse of a Deceased Retiree**

**Health Coverage Information**

| | | | | |
|---|---|---|---|---|
| **Plan:** | ❒ **Traditional** | ❒ **PPO** | ❒ **POS** ❒ **EPO** | ❒ **HMO** |
| **Type of Coverage:** | ❒ **Medical** | ❒ **Dental** | ❒ **Prescription** | ❒ **Vision** |
| **Level of Coverage:** | ❒ **Single** | ❒ **Parent/Child** | ❒ **Husband/Wife** | ❒ **Family** |

**Dependent(s) on Plan if any:**

| **Name(s)** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Coverage under the Plan will terminate on _____. Please send the aforementioned person (and his or her spouse and dependent child(ren), if any) the appropriate election notices and forms for COBRA continuation coverage within 14 days of the receipt of this notice, as required under COBRA.

Signature: _____ Title: _____