

COBRA Notice of Qualifying Event

Instructions: To notify ASI of an employee who has lost coverage or has had a COBRA qualifying event, please return this completed form to our office. Our contact information is below.

Employer Name: _____

Name of Qualified Beneficiary _____

First Date of Coverage: _____ **Beneficiary's Social Security #:** _____
(Active Group Coverage) _____ **Beneficiary's Mailing Address:** _____

Qualifying Event Information:

Qualified Beneficiary's Qualifying Event: Termination Reduction of hours
 Resignation/Retirement

Dependent Qualifying Event: Divorce or legal separation Death of covered employee
 Child no longer eligible

Date of the Qualifying Event: _____
 Date loss of coverage began or date of termination.

Qualified Beneficiaries:

<input type="checkbox"/>	Employee Name: (COBRA Beneficiary)	_____	Date of Birth:	_____
<input type="checkbox"/>	Spouse Name:	_____	Date of Birth:	_____
<input type="checkbox"/>	Dep Child Name:	_____	Date of Birth:	_____
<input type="checkbox"/>	Dep Child Name:	_____	Date of Birth:	_____
<input type="checkbox"/>	Dep Child Name:	_____	Date of Birth:	_____
<input type="checkbox"/>	Dep Child Name:	_____	Date of Birth:	_____

Spouse or Dependent Address:
 Complete if address is different than the primary beneficiary's address above.

Health Plans:

<input type="checkbox"/>	Medical Carrier:	_____	Rate Area:	_____
<input type="checkbox"/>	Dental Carrier:	_____	Rate Area:	_____
<input type="checkbox"/>	Vision Carrier:	_____	Rate Area:	_____
<input type="checkbox"/>	Other Plan/Carrier:	_____	Rate Area:	_____
<input type="checkbox"/>	Section 125 Plan:	_____	Election Amount and Balance:	_____
				Amount Balance

 Signature of employer or employer representative

 Date



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