CobraServ℠

COBRA QUALIFYING EVENT

CS-613/2/02

PLEASE CHECK ONE BOX ⇨ ❑ ORIGINAL NOTICE **If FAXED, do not mail copy.**
❑ REVISION . . . to a form that was previously sent.

1a) From (Company)

1b) Division or Region Code ☐☐ 1c) Company ID or Unit Code ☐☐

(If applicable, refer to the Client Rate Report for the one character to two characters required [alpha and/or numeric] to complete 1b and 1c above.)

2) CobraServ Account Number

3) Please be advised that the following has had a Qualifying Event. (check one)

❑ (E)mployee ❑ (D)ependent

4) Social Security Number of Qualified Beneficiary

☐☐☐-☐☐-☐☐☐☐

5a) Qualified Beneficiary's Name (last, first, mi)

5b) Street (include apartment number)

5c) City | 5d) State | 5e) Zip Code

6) Home Phone # of Qualified Beneficiary (include Area Code) ☐☐☐-☐☐☐-☐☐☐☐ | 7) Employee # (if applicable)

8) Date of Birth of Qualified Beneficiary ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y | 9) Gender (check one) ❑ (M)ale ❑ (F)emale

10) If the Qualified Beneficiary listed in box #5a is not the employee, enter the following:

Employee Name (last, first, mi)________________________________

Employee SSN ☐☐☐ – ☐☐ – ☐☐☐☐

Dependent's Relationship to Employee__________________________

11) Qualifying Event Date

☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

12) Last day of pre-COBRA Coverage (cannot be prior to Qualifying Event Date)

☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

13) Is this a second Qualifying Event for a dependent who is currently on COBRA? ❑ (N)o ❑ (Y)es

14) If employee, does he/she have a health care FSA?

❑ (N)o ❑ (Y)es (If yes, MONTHLY contribution $__________________)

15) Refer to your Client Rate Report and enter the current Carrier Option, Option Code and Plan Code for each coverage in effect on the Qualifying Event Date:

	Carrier Code	Option Code	Plan Code*
Med or HMO			
Dental			
Vision			
Hearing			
Prescription			
Other			

*Select from the following current Plan Code Coverages. CobraServ administers only Plan Code coverage options that are permitted by your plan or carrier:

1 = Individual	3 = Family	14 = Individual+Child
2 = Individual + 1	9 - Individual + Spouse	15 = Individual + Children

16) COBRA Qualifying Event that caused loss of coverage (check one)

Continuation of coverage for 18 months:

- ❑ Employee's retirement (Code 8)
- ❑ Employee's resignation (Code 1)
- ❑ Employee's involuntary termination (Code C)
- ❑ Employee's reduction in hours (Code 2)
- ❑ Employee's layoff (Code 0)
- ❑ Employee's begins leave of absence (Code 7)

Continuation of coverage for 36 months:

- ❑ Divorce/legal separation (Code 4)
- ❑ Ineligibility of dependent child (Code 6)
- ❑ Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage (Code 5)
- ❑ Death of covered employee/retiree (Code 3)
- ❑ Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy) United States Code (Code 7)

17) Spouse/Dependent Information. Each name should include last, first and middle initial.

Name of Spouse________________________________

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Date of Birth ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

Gender ❑ Male ❑ Female

Address (if different from participant)________________________________

Name of Dependent________________________________

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Date of Birth ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

Gender ❑ Male ❑ Female

Address (if different from participant)________________________________

Name of Dependent________________________________

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Date of Birth ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

Gender ❑ Male ❑ Female

Address (if different from participant)________________________________

Name of Dependent________________________________

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Date of Birth ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

Gender ❑ Male ❑ Female

Address (if different from participant)________________________________

Please see Addendum if additional names need to be listed in this section

Prepared By

Name: (PRINT)________________________________

Date ☐☐☐☐☐☐☐☐ M M D D Y Y Y Y

Telephone # ☐☐☐-☐☐☐-☐☐☐☐

Fax # ☐☐☐-☐☐☐-☐☐☐☐

CobraServ National Service Center • 3201 34th Street South • St. Petersburg, Florida 33711-3828 • 800-488-8757 • Fax 727-865-3648