

COBRA Event Notification

Employer: _____

Date: _____

Event

<input type="checkbox"/> New Participant	<input type="checkbox"/> Termination/Resignation/Retirement
<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss of Dependent Status
<input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Medicare Eligible
<input type="checkbox"/> Death	<input type="checkbox"/> End of FMLA Leave
<input type="checkbox"/> New Dependent	<input type="checkbox"/> Change of Address
Event Date: _____	

Complete Only Employee or Dependent Information that pertains to Event

Employee

Employee		SSN	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Phone	
Address			
City		State	Zip

Dependents (Note different addresses or additional dependents on a separate sheet)

Spouse	Name	SSN	Date of Birth
Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Child	Name	SSN	Date of Birth
Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Child	Name	SSN	Date of Birth
Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision			
Child	Name	SSN	Date of Birth
Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision			

Benefits

Benefit	Carrier/Plan	Monthly Premium	Effective Date	Termination Date
Health				
Dental				
Vision				
FSA	Beginning Balance: _____ Current Balance: _____			

Authorized Representative Signature: _____ Date: _____