Capital Administrators (CA)

COBRA Continuation Services - Benefit Termination Form

(Also used to collect information for current COBRA qualified beneficiaries when taking over COBRA administration)

(revised 5/20/2013)

INSTRUCTIONS: *Please print clearly*

1. Fill out one form per family unit (Qualified Beneficiary and Dependents)
2. Please check one box: ☐ Original notice (if faxed, do not mail copy) ☐ Revision to original

COMPLETE THIS FORM AND RETURN IT TO:
Capital Administrators
3819 Market Street
Camp Hill, PA 17011
Fax: 717-975-9303

1. Company:

2. Please be advised that the following is currently on COBRA Continuation (Check one box only): ☐ Employee ☐ Dependent

3. Social Security Number of Qualified Beneficiary: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

4. Name of COBRA Continuation continuant (last, first, mi):

5a. Street Address:	5b. City:	5c. State:	5d. Zip:

6. Home Phone:	7. Date of Birth:
8. Gender: ☐ Male ☐ Female	9. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

10. If the individual indicated in box #4 is a dependent of an employee/former employee, please complete the following:

Employee Name (last, first, mi):____________________________________Continuant's relationship to employee:_______________________

Employee's SSN: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

11. Qualifying Event that caused loss of coverage (check one):

Continuation of coverage for 18 months for Federal COBRA or 9 months for Mini-COBRA:

- ☐ Employee's **involuntary** termination of employment (except when due to gross misconduct)
- ☐ Employee's **voluntary** resignation/termination of employment
- ☐ Employee's retirement
- ☐ Employee's layoff or leave of absence - **Please circle one**
- ☐ Employee's reduction in work hours (includes work stoppage or strike)
- ☐ Other (please describe): ____

Continuation of coverage for 36 months for Federal COBRA or 9 months for Mini-COBRA:

- ☐ Death of covered employee/retiree
- ☐ Divorce/legal separation
- ☐ Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of group coverage
- ☐ Ineligibility of dependent child
- ☐ Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy)

EFFECTIVE DATE OF QUALIFYING EVENT INDICATED:

____

12. Last day of pre-COBRA coverage: ____

13. First premium due-date for which CA is to begin COBRA Continuation billing: ___________________________

14. What types of coverage is the continuant enrolled in: ☐ Health ☐ Vision ☐ Dental ☐ FSA ☐ Other ____________________

15. What tier is the continuant enrolled in for health? CA administers only plan code coverage options that are permitted by your plan or carrier.
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child ☐ Employee + Children ☐ Family

16. What tier is the continuant enrolled in for vision? CA administers only plan code coverage options that are permitted by your plan or carrier.
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child ☐ Employee + Children ☐ Family

17. What tier is the continuant enrolled in for dental? CA administers only plan code coverage options that are permitted by your plan or carrier.
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child ☐ Employee + Children ☐ Family

18. FSA Payroll Information:

Last payroll deduction amount (medical FSA)	_________________
Last payroll deduction amount (dependent care FSA)	_________________
Last payroll deduction date	_________________
Annual allocation (if CA is not the administrator)	_________________
Current plan year claims approved (if CA is not the administrator)	_________________

19. Has the continuant been approved for an additional 11-month disability extension? ☐ No ☐ Yes

20. At the time of the separation or reduction in hours was the employee eligible to receive Social Security income? ☐ No ☐ Yes

21. Form Complete by: Date: