COBRA Continuation Services
Qualifying Event Form

Used to report eligible employees and dependents of COBRA services

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1. Company:

2a. Qualified Beneficiary is: ☐ Employee ☐ Dependent

2b. This form is the: ☐ Original ☐ Revision

3. Social Security Number of Qualified Beneficiary:

4. Name of Qualified Beneficiary (last, first, mi):

5. Street Address: City: State: Zip:

6. Home Phone: ( )

7. Date of Birth:

8. Gender: ☐ Male ☐ Female

9. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

10. If the qualified beneficiary indicated in #4 is a dependent, please complete the following:

Employee Name (last, first, MI) Employee's SSN Relationship to Beneficiary

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

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

- ☐ Employee's **involuntary** termination of employment (except when due to gross misconduct)
- ☐ Employee's termination due to **Gross Misconduct**: Employer Will / Will Not Extend COBRA (**circle one**)
- ☐ Employee's **voluntary** resignation/termination of employment
- ☐ Employee's retirement
- ☐ Employee's layoff or leave of absence (**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 PA Mini-COBRA:

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

QUALIFYING EVENT DATE:
The date 11a happened

_____

12. Last day of pre-COBRA coverage (the last day on regular group coverage):

13. First premium due-date for which CRB will begin billing the COBRA beneficiary:

14. What lines of coverage is the beneficiary enrolled in:	☐ **Health**	☐ **Dental**	☐ **Vision**
15. What coverage tier is the beneficiary enrolled in for each coverage:	☐ Employee ☐ EE/Spouse ☐ EE/Child(ren) ☐ Family	☐ Employee ☐ EE/Spouse ☐ EE/Child(ren) ☐ Family	☐ Employee ☐ EE/Spouse ☐ EE/Child(ren) ☐ Family

18. Does your company offer an FSA: ☐ No ☐ Yes	Last payroll deduction amount (medical FSA) Last payroll deduction amount (dependent care FSA) Last payroll deduction date Annual allocation Current plan year claims approved	_____ _____ _____ _____

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. _____ Company Authorized Signature _____ Phone _____ Date