Clear Form

COBRA Qualifying Event Notification

Employer Name: _____

Type of Qualifying Event:

- ☐ QE1 Termination of Employment (other than by reason of gross misconduct)
- ☐ QE2 Reduction of Work Hours
- ☐ QE3 Employee's Entitlement to Medicare (COBRA for Dependents)
- ☐ QE4 Death of the Employee
- ☐ QE5 Divorce from Employee
- ☐ QE6 Legal Separation from Employee (court Ordered Marital Separation)
- ☐ QE7 Loss of Dependent Child Status
- ☐ QE8 Bankruptcy of the Plan Sponsor

Eligible Members

☐ Employee ☐ Dependent

Last Name:	*First Name:*		*SSN#*
Mailing Address:	*City:*	*ST:*	*ZIP Code:*
Date of Birth:	*Last Date Employed:*	*Coverage Termination Date (last day covered under your plan):*	
Is employee currently covered by Medicare? (Entitled)	☐ Yes	☐ No	

Covered Spouse

Last Name:	*First Name:*	*Date of Birth:*	*SSN#*
Mailing Address:	*City:*	*ST:*	*ZIP Code:*

Covered Children

Last Name:	*First Name:*	*Date of Birth:*
Last Name:	*First Name:*	*Date of Birth:*
Last Name:	*First Name:*	*Date of Birth:*
Last Name:	*First Name:*	*Date of Birth:*

Benefits Currently In Force	**Single**	**Employee + Spouse**	**Parent/Child**	**Family**
Medical				
Dental				
Vision				

Signature: _____ **Date:** _____