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Notice of Qualifying Event Form

(to be filled out by the employer)

Completion of This Form Authorizes Us To Send Out a Notice of Rights for COBRA Coverage

Group Name:_____ **Group Number:**_____

Employee Name: _____

Employee Address: _____

_____

SSN or Alt ID#: _____ Date of Qualifying Event: _____

Last Day of Coverage: _____ COBRA Start Date: _____

The following qualifying event has occurred or will occur for the person identified above. Check one:

- ☐ End of employment
- ☐ Reduction of hours
- ☐ Retirement
- ☐ Death of covered employee
- ☐ Divorce or legal separation (**list name of spouse and children losing coverage below**)
- ☐ Child's loss of dependent status (**list child's name below**)

Name of Spouse or Child: _____

Address (if different): _____

_____

Completed by: _____

Phone:_____ Date: _____