



COBRA Notification Request Form

FAX OR E-MAIL TO: COBRA

FAX #: (603) 647-4668

E-MAIL LTARRIER@BENSTRAT.COM

Employer Name _____ Division/Location# _____ Contact Person _____ Phone # _____ FAX # _____

TO BE COMPLETED BY EMPLOYER. PLEASE PROVIDE ALL OF THE FOLLOWING INFORMATION.
 INCOMPLETE FORMS WILL BE RETURNED, DELAYING COBRA NOTIFICATION.
 (Please type or print legibly, using black ink)

1. COBRA QUALIFYING EVENT (CHECK ONE)

- DATE OF EVENT: ___/___/___ BENEFITS PAID THRU: ___/___/___
- 1. Employee Termination of Employment (employee resigned, quit or was fired)
 - 2. Employee Retirement
 - 3. Employee's dependents lost coverage due to employee retirement, Medicare eligibility, etc.
 - 4. Employee's dependents lost coverage due to death of employee
 - 5. Dependent child becomes ineligible for coverage (age and/or non-student status)
 - 6. Reduced Hours, no longer eligible for benefits
 - 7. Employee loses coverage due expiration of Family Medical Leave of Absence
 - 8. Employee's dependents/spouse lost coverage due to Divorce or Legal Separation from employee
 - 9. Loss of coverage
 - 10. State continuation
 - 11. Termination with severance
 - 12. USERRA - military deployment

2. EMPLOYEE OR QUALIFYING COBRA BENEFICIARY INFORMATION

MEMBER/TELEPHONE # () _____ DATE OF HIRE: ___/___/___
 Title: Mr. ___ Mrs. ___ Ms. ___ Dr. ___

NAME _____ SS # OR ID #: _____ EMAIL: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SEX: M F IS EMPLOYEE TOTALLY DISABLED? Yes No (CIRCLE ONE)

3. PRESENT INSURANCE COVERAGES (PROVIDE NAMES OF PLANS, COVERAGE LEVELS, AND EFFECTIVE DATE OF COVERAGE)

	INSURANCE PLAN NAME (I.E. BLUE CHOICE, PPO, HMO, ETC.) <small>BE SPECIFIC</small>	COVERAGE LEVEL SINGLE, 2 PERSON, FAMILY	ORIGINAL EFFECTIVE DATE OF COVERAGE
MEDICAL PLAN			
DENTAL PLAN			
VISION PLAN			
HEALTH CARE REIMBURSEMENT ACCT	DOES EMPLOYEE HAVE AN ACCOUNT? Yes No (CIRCLE ONE)	ANNUAL ELECTION THIS PLAN YEAR: \$ _____	ACCOUNT CONTRIBUTION THIS PLAN YEAR TO DATE: \$ _____
EAP (EMPLOYEE ASSISTANCE PLAN)			

4. COVERED DEPENDENTS (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE)

	FULL NAME	DATE OF BIRTH	SEX	SOCIAL SECURITY #
SPOUSE:	_____	___/___/___	M F	___-___-___
CHILD:	_____	___/___/___	M F	___-___-___
CHILD:	_____	___/___/___	M F	___-___-___
CHILD:	_____	___/___/___	M F	___-___-___

* COMPLETE FOR CURRENT COBRA PARTICIPANTS ONLY *

Last Premium Amount Paid: \$ _____ For which month of coverage: _____
 Original COBRA Start Date: \$ _____