benefit strategies LLC

COBRA Notification Request Form

FAX #: (603) 647-4668 E-Mail: info@benstrat.com

Instructions: Please completely fill out this form to notify Benefit Strategies of new COBRA qualifying events. Incomplete and/or illegible forms will be returned, delaying COBRA notification. Letters will be generated within 3 business days upon receipt of completed COBRA Notification Request Form. **

**COBRA Notification may be submitted electronically by logging onto www.benstrat.com. Letters will be generated on the next business day upon completion of Electronic Notification. Please e-mail info@benstrat.com for your log-in information if needed.

1. Employer Information

Company Name_____ Division/Location_____

Contact Person:_____ Phone:_____

2. Employee or Qualified COBRA Beneficiary (QB) Information (All information is REQUIRED)

Qualified Beneficiary (QB) Name:_____ QB SSN:_____

QB Date of Birth:_____ QB Sex: ___M ___F QB Phone #: _____

QB Address:_____City,State,Zip:_____

Employee Name * (if not the QB):_____Employee SSN:_____

Employee Date of Birth:_____ Employee Sex: ___M ___F Phone #: _____

Date of Hire:_____ Is Employee Totally Disabled?: ___Yes ___No Date of Disability:_____

3. COBRA Qualifying Event (Please check one) *Employee Information Must be completed for Dependent Events.

Qualifying Event Date:_____ **Date benefits are paid through:**_____

- ☐ Employee Termination, Lay-off, or Resignation: **Please Check One:** _____Voluntary _____Involuntary
- ☐ Employee Termination - With Severance: When does COBRA Start? ___After Severance ___ As of Qualifying Event
- ☐ Employee Reduction of Hours - No Longer Eligible for Benefits
- ☐ Dependent Loss of Coverage due to Employee Retirement – Employee is not Electing COBRA Continuation *
- ☐ Dependent Loss of Coverage due to Employee Medicare Eligibility *
- ☐ Dependent Loss of Coverage due to Death of Employee *
- ☐ Dependent Child Loss of Coverage due to Loss of Eligible Dependent Status (Examples: Age / Non-student status) *
- ☐ Dependent Loss of Coverage due to Divorce or Legal Separation *
- ☐ Employee Loss of Coverage due to Expiration of Family Medical Leave of Absence
- ☐ State continuation of coverage
- ☐ Employee Retirement
- ☐ USERRA–military deployment (Uniformed Services Employment and Reemployment Rights Act of 1994)

4. Present Insurance Coverage (Please provide ALL Information & attach a copy of the Plan Design for EACH Plan)

Insurance Coverage Type	Insurance Plan Name (Clearly specify)	Coverage Level (Single, 2P, Family, etc)	Original Effective Date of Coverage
Medical Plan			
Dental Plan			
Vision			
EAP (EE Asst. Plan)			
HRA	Yes No (circle one)		
Flex Acct. (FSA)	Yes No (circle one) Plan Year End Date:_____	Annual Election this Plan Year: $_____ Contributions to Account YTD: $_____ Claims Paid from Account YTD: $_____	

5. Covered Dependents (Please provide ALL Information)

Dependent:	Full Name	Date of Birth	Sex	Social Security Number
Spouse			M F	
Child			M F	
Child			M F	
Child			M F	