HealthPlans, Inc.

COBRA Qualifying Event Notification **EMPLOYER:**

TYPE OF QUALIFYING EVENT:

- ☐ CQE1 Termination of Employment (other than by reason of gross misconduct)
- ☐ CQE2 Reduction of Work Hours
- ☐ CQE3 Employee's Entitlement to Medicare (COBRA for Dependents)
- ☐ CQE4 Death of the Employee
- ☐ CQE5 Divorce from Employee
- ☐ CQE6 Legal Separation from Employee (court Ordered Marital Separation)
- ☐ CQE7 Loss of Dependent Child Status
- ☐ CQE8 Bankruptcy of the Plan Sponsor

Eligible Members: ☐ Employee ☐ Dependent

Name: _____

Address: _____

_____

Social Security Number _____ / _____ / _____ 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:

Name: _____

Address: _____

_____

Social Security Number _____ / _____ / _____ Date of Birth _____ / _____ / _____

Covered Children:

Name: _____ Date of Birth _____ / _____ / _____

Name: _____ Date of Birth _____ / _____ / _____

Name: _____ Date of Birth _____ / _____ / _____

Benefits Currently In Force:	SINGLE	EMPLOYEE+SPOUSE	PARENT/CHILD	FAMILY
MEDICAL	_____	_____	_____	_____
DENTAL	_____	_____	_____	_____
VISION	_____	_____	_____	_____

SIGNATURE _____