



HEALTH BENEFIT PLANS

# COBRA Notification Request Form

FAX OR E-MAIL TO: SCHOOLCARE

FAX #: (603) 369-4200

E-MAIL COBRA@SCHOOLCARE.ORG

Employer Name

Division/Location

Contact Person

TO BE COMPLETED BY EMPLOYER. PLEASE PROVIDE ALL OF THE FOLLOWING INFORMATION.  
INCOMPLETE FORMS WILL BE RETURNED, DELAYING COBRA NOTIFICATION.

## 1. COBRA QUALIFYING EVENT (CHECK ONE)

DATE OF EVENT: \_\_\_\_\_

BENEFITS PAID THRU: \_\_\_\_\_

- \_\_\_\_ 1. Employee Termination of Employment:  **CHECK ONE** ▶  **Voluntary**  **Involuntary**
- \_\_\_\_ 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. Termination with severance:  **CHECK ONE** ▶  **COBRA starts after Severance**  **COBRA starts as of qualifying event**
- \_\_\_\_ 10. USERRA - military deployment -Uniformed Services Employment and Reemployment Act of 1994 (24 mos.)

## 2. EMPLOYEE OR QUALIFYING COBRA BENEFICIARY INFORMATION

DATE OF HIRE: \_\_\_/\_\_\_/\_\_\_

BIRTH DATE: \_\_\_/\_\_\_/\_\_\_

NAME

REQUIRED SS #:

EMAIL:

ADDRESS

CITY

STATE

ZIP

TELEPHONE # ( ) \_\_\_\_\_

GENDER: 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. HMO, OAPOS, OA+) BE SPECIFIC	COVERAGE LEVEL SINGLE, 2 PERSON, FAMILY	ORIGINAL EFFECTIVE DATE OF COVERAGE
MEDICAL PLAN:			
DENTAL PLAN:			
SECT. 125/ FSA ACCT:	DOES EMPLOYEE HAVE AN ACCOUNT? YES NO (CIRCLE ONE)	ANNUAL ELECTION THIS PLAN YEAR: \$ _____	ACCOUNT CONTRIBUTION THIS PLAN YEAR TO DATE: \$ _____

## 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: \_\_\_\_\_