



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
- ____ 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.)
- ____ 11. Other

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: \$ _____
	FSA PLAN YEAR END DATE: _____		CLAIMS PAID FROM ACCOUNT 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	- -