COBRA Qualified Beneficiary Notification Form

Fax To: (508) 739-2259 or Email To : Service@employeebenefitsinc.com

EMPLOYER	
Employer Name:	
Employer Contact:	Phone:

COBRA Beneficiary Information:			
Employee Name:		Social Security #:	
Mailing Address:		City:	
State	Zip:	Phone:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Date of Birth:	Qualifying Event Date:	Last Date of Coverage:	
COBRA Premium Paid Through Date:	COBRA Start Date:	Date of Hire:	
Qualifying Event: ☐ Termination ☐ Death ☐ Medical Leave ☐ Medicare ☐ Reduction in Hours ☐ Total Disability ☐ Divorce ☐ Dependent(s) no longer Covered			
If Termination of Employment was it?: ☐ Voluntary or ☐ Involuntary			
If a California resident, is this QB eligible for California COBRA?			

Covered Dependents:		
Name of Dependents:	Date of Birth:	Social Security #:

Insured Employee (Complete only if Beneficiary is NOT the insured employee)			
Employee Name:			Social Security #:
Mailing Address:			
City:	State:	Zip:	Phone:
Relationship to Beneficiary:			

Continuing Coverage			
Benefits Available:	Insurance Company/ Product or Plan Name:	Current Coverage (Ind, 2Person, Fam)	Original Effective Date Of Insurance Coverage
Health Insurance Coverage			
Dental Insurance Coverage			

Severance Agreement
This COBRA Notification is Subject to a Severance Agreement: ☐ Yes ☐ No
The Employer Agrees to pay for the Beneficiary's COBRA coverage through the following date:
This severance is intended to be: ☐ part of **OR** ☐ in addition to the required COBRA period

Authorized Employer Signature:	Date:

Please send this form to Employee Benefits Solutions within 14 days of the qualifying event date.