

COBRA NOTIFICATION INFORMATION FORM

SECTION A: MEMBER PERSONAL INFORMATION (to be completed by employer)

Last Name:	First Name:	M.I.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Street Address:	City:	State:	Zip code:
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If this is a dependent qualifying event, please provide the employee's name here:

Note: If any spouse/covered dependent(s) reside at a separate address, please provide address below.

Spouse/Dependent(s) Name	Street Address	City	State	Zip code

SECTION B: QUALIFYING EVENT INFORMATION

Date of Qualifying Event:	Benefits Termination Date:	Date of Hire:	Date employee joined Health Plan:
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Qualifying Event (please specify):

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| <input type="checkbox"/> Voluntary Termination | <input type="checkbox"/> Loss of coverage due to employee Medicare entitlement |
| <input type="checkbox"/> Involuntary Termination | <input type="checkbox"/> Dependent ceasing to qualify under the plan |
| <input type="checkbox"/> Reduction in Hours | <input type="checkbox"/> Death of Employee |
| <input type="checkbox"/> Divorce or Legal Separation | <input type="checkbox"/> Loss of coverage due to call to active military duty |
| <input type="checkbox"/> Other | |

SECTION C: INDIVIDUALS ENROLLED IN BENEFIT PLAN(S) on the day before the qualifying event.

(Include employee and/or dependents)

Last Name	First Name	M.I.	Date of Birth	Sex M/F	Effective Date	Social Security Number	Relationship to Employee
						- -	
						- -	
						- -	
						- -	

SECTION D: BENEFITS SUBJECT TO COBRA

(i.e. medical, dental, and vision coverage held by individuals listed in Section C)

Group Number	Insurance Company	Type of Insurance (Medical, Dental, etc.)	Type of Plan (HMO, PPO, etc.)	Individuals Covered

SECTION E: Severance Agreement (If applicable)

The employer agrees to pay for the Cobra coverage through the following date:

Name of Employer: Steve P. Rados, Inc.	Name of HR Rep:	Date Completed:
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