HR Concepts, LLC

"Your Third Party Administrator of Choice"

COBRA NOTIFICATION REQUEST FORM

Fax to: The Cobra Department FAX #: 866-978-7868 E-mail: cobra@hrconcepts.biz

Employer Name	Division/Location	Contact Person	Phone #	FAX #

Please provide ALL of the following information.

1) COBRA Qualifying Event (Check One) **Date of Event: ____/____/____**

____ 1) Employee Termination of Employment (Involuntary)
____ 2) Employee Termination of Employment (Voluntary: Quit or Resigned)
____ 3) Employee Retirement
____ 4) Employee's dependents lost coverage due to employee retirement, medicare eligibility, etc.
____ 5) Employee's dependents lost coverage due to death of employee
____ 6) Dependent child becomes ineligible for coverage (age and/or non-student status)
____ 7) Reduced Hours, no longer eligible for benefits
____ 8) Employee loses coverage due to taking a leave of absence under the Family Medical Leave Act
____ 9) Employee's dependents/spouse lost coverage due to Divorce or Legal Separation from employee
____ 10) Other ____

2) Employee or Qualifying COBRA Beneficiary Information EE/Telephone#________________

Name ____________________________________ SS#____________________________

Address________________________________City______________State_________Zip_______

Date of Birth: ____/_____/_____ **Sex:** M F **Is Employee totally disabled?** Yes No

3) Present Insurance Coverages: Provide names of plans, coverage levels, and effective date of coverage.

	Insurance Plan Name Ex: BlueChoice, Tufts HMO, etc BE SPECIFIC!	**Coverage Level** Single, 2 Person, Family	**Original Effective Date Of Coverage**
Medical Plan			
HRA Plan	**Amount left to spend:**__________		
Dental Plan			
Vision Plan			
FSA Account	**Does Employee have an account?** **Yes** **No**	**Annual Election This plan year** $__________	**Account contributions this plan year to date:** $__________

4) Covered Dependents **(Please provide as much information as possible)**

Full Name	Date of Birth	Sex	Social Security No
Spouse: ________________________	_____/_____/_____	M F	_______-________-__________
Child: ________________________	_____/_____/_____	M F	_______-________-__________
Child: ________________________	_____/_____/_____	M F	_______-________-__________
Child: ________________________	_____/_____/_____	M F	_______-________-__________

---------- Complete for Current COBRA Participants Only ----------

Last Amount Paid: $_______ For Which Month of Coverage:_________ Original COBRA Start Date:_______

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