

FAX

COBRA QE REQUEST

BENEFITHELP

Solutions®

DATE: _____ **REQUEST #** _____ **of** _____
TO: BenefitHelp Solutions COBRA
FAX: 888 393-2943 **TEL:** 800 822-3173
FROM: _____
COMPANY: _____
FAX: _____ **TEL:** _____

Please send a COBRA Election Notice as indicated below:					
QUALIFYING EVENT (REASON COVERAGE ENDING)		DATE OF QUALIFYING EVENT		DATE COVERAGE ENDS	
NAME OF QUALIFIED BENEFICIARY (PERSON LOSING COVERAGE)				SOCIAL SECURITY NUMBER	
MAILING ADDRESS					
NAME OF COVERED EMPLOYEE (IF DIFFERENT)				SOCIAL SECURITY NUMBER	
LIST ALL COVERED INDIVIDUALS INCLUDING QUALIFIED BENEFICIARY	SSN	GENDER	RELATION	ENROLLED IN MEDICAL PLAN?	ENROLLED IN DENTAL PLAN?
Qualified Beneficiary	See above		Self		

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