

# COBRA Qualifying Event request form

1560 (5/21)



**PLEASE PRINT CLEARLY**

**\* This information is mandatory.** Processing may be delayed if fields with an asterisk are not filled out.

## Section 1 Group information

* Date ____/____/____	* Name
* Contact email address	

Please send a COBRA Election Notice as indicated below\*

## Section 2 Qualified beneficiary information

* Client name		* Client division	
* First name	M.I.	* Last name	
* Date of birth ____/____/____	* SSN or BHS Identification number		* <input type="checkbox"/> Male * <input type="checkbox"/> Female
* Mailing address		* City	* State * ZIP
* Email address		* Contact phone number	

## Section 3 Eligible dependents

* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____	* Relationship
* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____	* Relationship
* First name	* Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	* Social Security number	* Date of birth ____/____/____	* Relationship

## Section 4 Qualifying event information

<input type="checkbox"/> Involuntary termination	<input type="checkbox"/> Divorce**	* Original enrollment date	* Date of qualifying event	* Date coverage ends
<input type="checkbox"/> Voluntary termination	<input type="checkbox"/> Ineligible dependent **	____/____/____	____/____/____	____/____/____
<input type="checkbox"/> Reduction in hours	<input type="checkbox"/> Death of employee **			
<input type="checkbox"/> Leave of absence	<input type="checkbox"/> Other **			

\*\* Please provide additional information below if the Qualified Beneficiary experienced one of the indicated (\*) Qualifying Events. If the Qualified Beneficiary is not the employee, please provide the employee name and SSN.

\_\_\_\_\_

## Section 5 Qualified beneficiary plans

Plan type	Plan name	Family tier
Medical		
Dental		
Vision & RX		
FSA (amount per month)		
HRA		
EAP		

## Section 6 Subsidy

Flat amount or % _____ Length of time _____ (months)
--