

FAX

COBRA QE REQUEST



DATE: _____ REQUEST # _____ OF _____

TO: BenefitHelp Solutions COBRA

FAX: 888-393-2943 or 503-765-3453

TEL: 800-556-3137 or 503-765-3581

E-MAIL: _____

FROM: _____

COMPANY: _____

FAX: _____

TEL: _____

Please send a **COBRA Election Notice** as indicated below

Qualified Beneficiary Information:

Client Name: _____

Client Division: _____

First Name: _____

Last Name: _____

Mailing Address: _____

Social Security Number: _____

Gender: M / F

D.O.B: _____

Qualifying Event Information:

Qualifying Event Type (*Please check one*):

- Involuntary Termination
- Voluntary Termination
- Reduction in Hours
- Leave of Absence
- Divorce *
- Ineligible Dependent *
- Death of Employee *
- Other: _____

Date of Qualifying Event: _____

Original Coverage Effective Date: _____

Date Coverage Ends: _____

* Please fill out additional information in this box if the Qualified Beneficiary experienced one of the indicated Qualifying Events

Employee's Name: _____

SSN: _____ DOB: _____

Notes: _____

Qualified Beneficiary Plans:

| Plan type | Plan Name | Family Tier |
|-----------------|-----------|-------------|
| MEDICAL | | |
| DENTAL | | |
| VISION | | |
| FSA / HRA / EAP | | |

Qualified Beneficiary *Dependent* Information:

Please complete the below as applicable for each Dependent

| Name | SSN | DOB | Gender | Relationship |
|------|-----|-----|--------|--------------|
| | | | | |
| | | | | |
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