COBRA Qualifying Event request form

BenefitHelp SOLUTIONS

32162367 (12/18)

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
* Mailing address		* City	* State	* ZIP
* Email address			* Contact phone number	

Section 3 Eligible dependents

* First name	* Last name	☐ Male ☐ Female	* Social Security number	* Date of birth ____/____/____	* Relationship
* First name	* Last name	☐ Male ☐ Female	* Social Security number	* Date of birth ____/____/____	* Relationship
* First name	* Last name	☐ Male ☐ Female	* Social Security number	* Date of birth ____/____/____	* Relationship

Section 4 Qualifying event information

☐ Involuntary termination ☐ Voluntary termination ☐ Reduction in hours ☐ Leave of absence	☐ Divorce** ☐ Ineligible dependent ** ☐ Death of employee ** ☐ Other **	* Original enrollment date ____/____/____	* Date of qualifying event ____/____/____	* Date coverage ends ____/____/____

** 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)		

Section 6 Subsidy

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

Please return to your human resources or benefits department upon completion.

Questions? Contact BenefitHelp Solutions at 888-398-8057.