

**TERMINATION & COBRA Qualifying Event Notification Form
for COBRA Continuation Coverage**

Notice Reporting Date: _____

Employer's Name: _____

Qualified Beneficiary Information

Name: Last	First	Middle	Social Security Number	
Address: Street	City		State	Zip Code
Date of Birth: ____/____/____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married			
No. of Dependent Children: _____	Date of Hire: ____/____/____			

On _____, the above qualified beneficiary incurred the following "qualifying event" for purposes of COBRA continuation coverage:

- | | |
|--|--|
| <input type="checkbox"/> Involuntary Resignation | <input type="checkbox"/> Dependent Child has reached the age Maximum |
| <input type="checkbox"/> Voluntary Resignation | <input type="checkbox"/> No longer a Full Time Student |
| <input type="checkbox"/> Reduction in Hours | <input type="checkbox"/> Former Spouse of an Employee |
| <input type="checkbox"/> Discharge (Misconduct) | <input type="checkbox"/> Former Spouse of a Retiree |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Death of an Employee |
| <input type="checkbox"/> Employee's Medicare Entitlement | <input type="checkbox"/> Death of a Retiree |
| <input type="checkbox"/> Start of bankruptcy proceeding | <input type="checkbox"/> Surviving Spouse of a Deceased Retiree |

Health Coverage Information

Plan: Traditional Health Care Choice POS PPO HMO
 Type of Coverage: Medical Dental Prescription Vision
 Level of Coverage: Single Parent/Child Husband/Wife Family

Dependent(s) on Plan if any:

Name(s) _____	Relationship _____
_____	_____
_____	_____
_____	_____

Coverage under the Plan will terminate on _____. Please send the aforementioned person (and his or her spouse and dependent child(ren), if any, the appropriate election notices and forms for COBRA continuation coverage within fourteen (14) days of the receipt of this notice, as required under COBRA.

Signature _____ Date _____