



# COBRA NOTIFICATION REQUEST FORM

FAX OR E-MAIL TO: SUE STUART

FAX #: (603) 647-4668

E-MAIL: SSTUART@BENSTRAT.COM

Employer Name \_\_\_\_\_ Division/Location# \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ FAX # \_\_\_\_\_

**PLEASE PROVIDE ALL OF THE FOLLOWING INFORMATION.  
INCOMPLETE FORMS WILL BE RETURNED, DELAYING COBRA NOTIFICATION.  
(Please type or print legibly, using black ink)**

1.) COBRA QUALIFYING EVENT (CHECK ONE) DATE OF EVENT:     /     /     EMPLOYER PAID THROUGH:     /     /

- 1.) Employee Termination of Employment (employee resigned, quit or was fired)
- 2.) Employee Retirement
- 3.) Employee's dependents lost coverage due to employee retirement, medicare eligibility, etc.
- 4.) Employee's dependents lost coverage due to death of employee
- 5.) Dependent child becomes ineligible for coverage (age and/or non-student status)
- 6.) Reduced Hours, no longer eligible for benefits
- 7.) Employee loses coverage due expiration of Family Medical Leave of Absence
- 8.) Employee's dependents/spouse lost coverage due to Divorce or Legal Separation from employee
- 9.) Other \_\_\_\_\_

2.) EMPLOYEE OR QUALIFYING COBRA *BENEFICIARY INFORMATION* EMPLOYEE/TELEPHONE # (     ) - \_\_\_\_\_

NAME		SOCIAL SECURITY #	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH ____/____/____	SEX:   M   F	IS EMPLOYEE TOTALLY DISABLED?	YES   NO (CIRCLE ONE)

3.) PRESENT INSURANCE COVERAGES: PROVIDE NAMES OF PLANS, COVERAGE LEVELS, AND EFFECTIVE DATE OF COVERAGE.

	INSURANCE PLAN NAME (I.E. BLUE CHOICE, PPO, HMO, ETC.) BE SPECIFIC	COVERAGE LEVEL SINGLE, 2 PERSON, FAMILY	ORIGINAL EFFECTIVE DATE OF COVERAGE
MEDICAL PLAN			
DENTAL PLAN			
VISION PLAN			
HEALTH CARE REIMBURSEMENT ACCOUNT	DOES EMPLOYEE HAVE AN ACCOUNT? YES   NO (CIRCLE ONE)	ANNUAL ELECTION THIS PLAN YEAR: \$ _____	ACCOUNT CONTRIBUTION THIS PLAN YEAR TO DATE: \$ _____

4.) COVERED DEPENDENTS (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE)

	FULL NAME	DATE OF BIRTH	SEX	SOCIAL SECURITY #
SPOUSE:		/ /	M   F	-   -
CHILD:		/ /	M   F	-   -
CHILD:		/ /	M   F	-   -
Child:		/ /	M   F	-   -

**COMPLETE FOR CURRENT COBRA PARTICIPANTS ONLY**

Last Premium Amount Paid:     \$ \_\_\_\_\_ For which month of coverage: \_\_\_\_\_  
Original COBRA Start Date:     \$ \_\_\_\_\_