

# COBRA Notification Request Form

E-MAIL TO:  
CUSTOMERSERVICE@GORDONANALYTIC.COM

FAX: 781-891-1555

**Employer Name**      **Division/Location#**      **Contact Person**      **Phone #**      **FAX #**

TO BE COMPLETED BY EMPLOYER. 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: \_\_\_\_\_ BENEFITS PAID THRU: \_\_\_\_\_

- \_\_\_\_\_ 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 ineligible for coverage (age and/or non-student status) **(Complete as EMPLOYEE)**
- \_\_\_\_\_ 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. Loss of coverage
- \_\_\_\_\_ 10. State continuation
- \_\_\_\_\_ 11. Termination with severance
- \_\_\_\_\_ 12. USERRA - military deployment -Uniformed Services Employment and Reemployment Act of 1994 (24 mos.)

## 2. EMPLOYEE OR QUALIFYING DEPENDENT INFO

TELEPHONE # \_\_\_\_\_ ( ) \_\_\_\_\_ DATE OF HIRE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Title: Mr. \_\_\_\_ Mrs. \_\_\_\_ Ms. \_\_\_\_ Dr. \_\_\_\_ child \_\_\_\_\_

EMP (OR DEP) NAME \_\_\_\_\_ SS # OR ID #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

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 ACCT	DOES EMPLOYEE HAVE AN ACCOUNT? YES      NO (CIRCLE ONE)	ANNUAL ELECTION THIS PLAN YEAR: \$ _____	ACCOUNT CONTRIBUTION THIS PLAN YEAR TO DATE: \$ _____
EAP (EMPLOYEE ASSISTANCE PLAN)			

## 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: \$ \_\_\_\_\_