



**Employer / Employee Notification – COBRA Qualifying Event(s) or Changes**

PQB Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Sex:  Male  Female Date of Birth: \_\_\_\_\_  
Area Code City State Zip Code

Spouse's Name: \_\_\_\_\_ Spouse's D.O.B.: \_\_\_\_\_ Spouse's SS #: \_\_\_\_\_

Spouse's Address: \_\_\_\_\_  
(If different than employee)

<u>Dependent's Name(s):</u>	<u>Date of Birth:</u>	<u>Social Security Number:</u>	<u>Sex:</u>
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

**Event Codes**

- 01 Voluntary Termination - Employee and covered dependents
- 02 Involuntary Termination - Employee and covered dependents
- 03 Voluntary Retirement - Employee and covered dependents
- 04 Involuntary Retirement - Employee and covered dependents
- 05 Medicare Entitlement - Dependents of Employee, formerly covered by Employee's benefits, no longer covered because of Medicare entitlement
- 06 Death - Dependents of Employee losing coverage due to employee death
- 07 Ineligible Dependent - Dependent child of Employee who becomes ineligible for dependent coverage
- 08 Reduced Hours - Employee and covered dependents
- 09 Leave of Absence - Family/Medical - Designed for employees that are taking a leave of absence under the Family Medical Leave Act of 1993
- 10 Divorce or Separation - Dependents of employee losing coverage due to divorce or separation
- 11 Employer Bankruptcy - Employee and covered dependents
- 12 State Continuation - Covers state continuation of coverage
- 13 Voluntary Layoff - with Severance What is the severance agreement pertaining to COBRA Benefits **only**?  
 Dollar Amount or % \_\_\_\_\_ Length of agreement \_\_\_\_\_
- 14 Involuntary Layoff - with Severance What is the severance agreement pertaining to COBRA Benefits **only**?  
 Dollar Amount or % \_\_\_\_\_ Length of agreement \_\_\_\_\_
- 15 Voluntary Layoff - w/o Severance
- 16 Involuntary Layoff - w/o Severance
- 17 Other - Please explain \_\_\_\_\_

**PLEASE SEE REVERSE SIDE**

**Event Information**

Date of Event: \_\_\_\_\_ Date Notified of Event: \_\_\_\_\_ Date of Secondary Event: \_\_\_\_\_  
(If applicable)

Last Day of Coverage: \_\_\_\_\_

**Coverage's to be included in COBRA notice:** (Check all that apply)

Medical    Dental    Vision    Prescription    FSA Balance \$ \_\_\_\_\_    HRA Balance \$ \_\_\_\_\_

**Coverage level:**

PQB Only    PQB and Spouse    PQB plus One    PQB and Child(ren)    PQB & Family

(PQB – Primary Qualified Beneficiary)

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Employer Contact Phone: \_(\_\_\_\_\_) \_\_\_\_\_

Employer Contact Email: \_\_\_\_\_

Date Form Completed: \_\_\_\_\_

Please send this form to: Specialty Services Unit  
1975 Tamarack Road  
P.O. Box 1096  
Newark, Ohio 43058-1096  
  
Phone: 800-297-1849  
Fax: 740-522-7483  
Email: admin@medben.com