



Specialty Services Unit
 1975 Tamarack Road
 P.O. Box 1096
 Newark, Ohio 43058-1096

ML - 16

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

PQB Name: _____ PID#: _____

Address: _____

City _____ State _____ Zip Code _____

Phone Number: (____) _____ Sex: Male Female Date of Birth: _____
Area 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 COMPLETE THE 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 \$ _____
 Date of last FSA payroll deduction: _____

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