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: _____

Spouse's Name: _____ Spouse's D.O.B.: _____ Spouse's SS #: _____

Spouse's Address: _____
(If different than employee)

| Dependent's Name(s): | Date of Birth: | Social Security Number: | Sex: |
|---|---|---|---|
| _____ | _____ | _____ | ☐ Male ☐ Female |
| _____ | _____ | _____ | ☐ Male ☐ Female |
| _____ | _____ | _____ | ☐ Male ☐ Female |
| _____ | _____ | _____ | ☐ Male ☐ 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: _____

**Coverages 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