

INSTRUCTIONS: Please fill out this two-page form completely for each qualifying event. Return completed form (both pages) by Fax: (800) 482-4164
 Email: ALCclientservices@benefitadminsolutions.com

Employer Information – Do not leave blank. This section must be completed.

Employer Name	Division/Location	FEIN
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Employee Information – Do not leave blank. This section must be completed.

Last Name	First Name	Middle Initial	Date of Birth	SSN or Alternate ID	Gender (M/F)
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Primary Qualified Beneficiary Information – Complete this section for any employee, former employee, spouse or dependent that has had a qualifying event. COBRA election notification will be addressed and sent to this individual.

<input type="checkbox"/> Same as above	Last Name	First Name	Middle Initial	Date of Birth	SSN	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Street address			City	State	Zip	

Please complete "Additional Plan Participant Information" on page 2 of this document (if applicable)

Qualifying Event Information – To be completed by employer for every qualifying event (check only one).

Employee Qualifying Event: <input type="checkbox"/> Termination (i.e. involuntary.) <input type="checkbox"/> Reduction of hours (i.e. severance, workers' comp, non-FMLA leave of absence, etc.) <input type="checkbox"/> Layoff <input type="checkbox"/> Resignation	Dependent Qualifying Event: <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Child no longer eligible <input type="checkbox"/> Employee Medicare entitled* <input type="checkbox"/> Death of covered employee/retiree <input type="checkbox"/> Retirement
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Date of the qualifying event (date the above event occurred)	Date employee became entitled to Medicare* (if applicable)
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*Employee is Medicare entitled if over age 65 and receives or has applied for Social Security benefits.

Coverage Data – Please complete this section to report coverage information.

Date waiting period or affiliation period (if any) began*	Date health coverage began
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**Waiting period: period that must pass before an employee or dependent is eligible for benefits under the plan. Affiliation period: (HMOs only) Period not to exceed two months during which an enrollee does not receive benefits and is not charged for premiums.*

Rate and Benefit Information – Do not add the 2% administration fee. *NOTE: Only enter rate information if the plan is age and/or area rated.

	Medical	Dental	Vision	Other #1:	Other #2:
Plan name					
Plan type (HMO, PPO, etc.)					
Coverage code (i.e. EEO, EES, FAM, etc.) (See list of coverage codes below)					
Date of last day of active coverage					
Premium Amount (do not add 2% administration fee)* IMPORTANT: Only enter rate information if the plan is age and/or area rated					
Health FSA contribution (per month)	The health FSA should only be offered to eligible individuals. Please review your health FSA plan documentation if you need assistance in determining COBRA eligibility for health FSA plan participants.				

Employer Certification

By completing and returning this document, I attest that the information submitted is accurate to the best of my knowledge. I understand that any unanswered questions may result in delays in the processing of this form.

Name	Date	Telephone Number	Email Address
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Coverage Code Information: **EEO-** Employee only; **SPO-** Spouse only; **EES-** Employee plus spouse; **EEC-** Employee plus one child; **ECN-** Employee plus children; **SPC-** Spouse and child(ren); **CHO-** Child Only; **CHN-** Children only; **FAM-** Family coverage

Additional Plan Participant Information – Please complete the following fields for any individuals losing coverage due to this qualifying event. Only complete the address information if it is different from the address provided for the Primary Qualified Beneficiary on page 1 of this document.

Spouse Information					
Last Name		First Name		Middle Initial	Social Security Number
Date of Birth	Gender (M/F)	Date waiting period or affiliation period (if any) began		Date health coverage began	
Street Address			City	State	Zip
This individual was covered under the following plans the day before the qualifying event: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other #1 <input type="checkbox"/> Other #2					

Dependent # 1 Information					
Last Name		First Name		Middle Initial	Social Security Number
Date of Birth	Gender (M/F)	Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date waiting period or affiliation period (if any) began		Date health coverage began
Street Address			City	State	Zip
This individual was covered under the following plans the day before the qualifying event: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other #1 <input type="checkbox"/> Other #2					

Dependent #2 Information					
Last Name		First Name		Middle Initial	Social Security Number
Date of Birth	Gender (M/F)	Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date waiting period or affiliation period (if any) began		Date health coverage began
Street Address			City	State	Zip
This individual was covered under the following plans the day before the qualifying event: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other #1 <input type="checkbox"/> Other #2					

Dependent #3 Information					
Last Name		First Name		Middle Initial	Social Security Number
Date of Birth	Gender (M/F)	Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date waiting period or affiliation period (if any) began		Date health coverage began
Street Address			City	State	Zip
This individual was covered under the following plans the day before the qualifying event: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other #1 <input type="checkbox"/> Other #2					

Dependent #4 Information					
Last Name		First Name		Middle Initial	Social Security Number
Date of Birth	Gender (M/F)	Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date waiting period or affiliation period (if any) began		Date health coverage began
Street Address			City	State	Zip
This individual was covered under the following plans the day before the qualifying event: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other #1 <input type="checkbox"/> Other #2					

If necessary, you may complete an additional sheet to communicate additional participant information.