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COBRA Notice of Dependent Qualifying Event Form

Step 1: **Dependent Information** *=Required

*Client Name (do not abbreviate)

*Division Name (if applicable)

*Name of Former Dependent to be offered COBRA (First, Middle Initial, Last)

*Gender (M/F)

*Date of Birth (mm/dd/yyyy)

*Initial Date of Active Coverage (mm/dd/yyyy)

*Social Security Number

*Mailing Address

Daytime Phone

*City

*State

*Zip

Step 2: *Qualifying Event Information

*Qualifying Event Date (mm/dd/yyyy)

*First Day of COBRA Eligibility (mm/dd/yyyy)

***Qualifying Event Type**

☐ Death of Covered Employee ☐ Divorce / Legal Separation ☐ Child Losing Dependent Status ☐ Employee Covered by Medicare

*Covered Employee Name (First, Middle Initial, Last)

***Employee Social Security Number**

***Notice of Unavailability:** ☐ No ☐ Yes, please indicate reason:

Step 3: Current Benefits

☐ **Health**

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

☐ **Dental**

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

☐ **Vision**

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

☐ **Flexible Spending Account**

*Annual Election Amount $
*Benefit Last Date of Coverage
*Plan Year Start Date
*Plan Year End Date

☐ **Other Health Plan**

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

☐ **Severance** Enter the amount (flat rate or percentage) to be applied to the QB's monthly premium.

	Amount	Start Date	End Date
Medical			
Dental			
Vision			

Step 4: Other Covered Family Members

*Dependent(s) Name	*Relationship (ex. child)	*Social Security Number	*Date of Birth	*Gender

Step 5: Employer Authorization

I hereby certify that the information contained above is accurate to the best of my knowledge. I understand that PacificSource Administrators will not be held liable for missing or inaccurate information.

*Completed By: *Daytime Phone Number *Date: