COBRA Administration

QUALIFYING EVENT NOTIFICATION FORM

(Revised 04/01/17)

Employer Name: _____

Employee Name: _____

Residence Mailing Address: _____

Residence City, State, ZIP: _____

Social Security #: _____

Date of Birth: _____

Date of Hire: _____

Date Coverage FIRST Effective: _____

Qualifying Event:

Involuntary Termination: ___ Voluntary Resignation: ___ Reduction of Work Hours: ___

Employee Death: ___ Divorce or Legal Separation: ___ Loss of Dependent Status: ___

Medicare Entitlement: ___ Retirement: ___ Other: _____

Date of Qualifying Event: _____ *(Date that it actually happened, not date change effective)*

English or Spanish Notice: English: ___ Spanish: ___

Health Insurance Plan Selected: _____

Employee Only: ___ EE & Spouse: ___ EE & Children: ___ Family: ___ **WAIVED:** ___

Monthly Premium for Health Plan: _____

Dental Insurance Plan Selected: _____

Employee Only: ___ EE & Spouse: ___ EE & Children: ___ Family: ___ **WAIVED:** ___

Monthly Premium for Dental Plan: _____

Other Insurance Plan Selected:
(Vision, Chiropractic, Mental Health): _____

Employee Only: ___ EE & Spouse: ___ EE & Children: ___ Family: ___ **WAIVED:** ___

Monthly Premium for Other Plan: _____

Flexible Spending Plan: *Monthly Amount Contributed:* _____

Spouse Name: _____ Birth Date: ___/___/___

Children's Names & Birth Dates: _____

Different Address for Dependents?: _____

Fax this form to: **(877) 901-5522**

or

email this form to: cobra@ua-insurance.com

United Agencies Inc. INSURANCE

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