

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 Res	signation:	Reduction of Work	(Hours:
Employee Death: Divorce or Legal Sep		gal Separation:	Loss of Dependen	nt Status:
Medicare Entitlement:	Retirement: _	_	Other:	
Date of Qualifying Event:		(Date that i	t actually happened,	not date change effective)
English or Spanish Notice:	English:	Spanis	h:	
Health Insurance Plan Selected:				
Employee Only: EE & S	Spouse:	EE & Children:	Family: _	WAIVED:
Monthly Premium for Health Plan:				
Dental Insurance Plan Selected:				
Employee Only: EE & S	Spouse:	EE & Children:	Family: _	WAIVED:
Monthly Premium for Dental Plan:				
Other Insurance Plan Selected: (Vision, Chiropractic, Mental Healt	th):			
Employee Only: EE & S	Spouse:	EE & Children:	Family: _	WAIVED:
Monthly Premium for Other Plan:				
Flexible Spending Plan:	Monthly Amou	unt Contributed:		
Spouse Name:			Birth Date	e:/
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



(800) 800-5880 www.ua-insurance.com/cobra