

COBRA: Qualifying Event Notice



1. Employee information

Employer name _____ Division name _____
Employee name (first, middle initial, last) _____ Sex assigned at birth (M/F) _____
Date of birth (mm/dd/yyyy) _____ Hire date (mm/dd/yyyy) _____ SSN _____
Mailing address _____ Daytime phone _____
City _____ State _____ Zip _____

2. Qualifying event information

Event date (mm/dd/yyyy) _____ Original enrollment date/hire date (mm/dd/yyyy) _____

Event type:

Voluntary termination Reduction in hours Loss of eligibility Reservist called to active duty
Involuntary termination Retirement Employer bankruptcy

Notice of unavailability:

N/A Yes. Please indicate reason:

Gross misconduct Termination prior to active benefits Other _____

3. Current benefits

Medical

Carrier name _____
Plan name _____
Coverage level _____
Last coverage date _____

Dental

Carrier name _____
Plan name _____
Coverage level _____
Last coverage date _____

Vision

Carrier name _____
Plan name _____
Coverage level _____
Last coverage date _____

Flexible spending account

Annual election amount _____
Last day of coverage _____
Plan year start date _____
Plan year end date _____

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Other health plan

Carrier name _____
Plan name _____
Coverage level _____
Last coverage date _____

Severance

Enter the amount (flat rate or percentage) to be applied to the participant’s monthly premium.

Medical: amount, start date, and end date _____
Dental: amount, start date, and end date _____
Vision: amount, start date, and end date _____

4. Other covered family members

Spouse name (first, middle initial, last) _____

Date of birth (mm/dd/yyyy) _____ SSN _____

Mailing address (if different from employee address) _____

City _____ State _____ Zip _____

Dependent name	Relationship (example: child)	Social Security number	Date of birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Employer authorization

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

Completed by _____ Phone _____ Date _____

Please send this form to PacificSource Administrators and retain a copy for your records.

- Email: COBRA@PacificSource.com
- Mail to PSA, PO Box 71096, Springfield OR 97475
- Fax: **541-225-3684**

Questions? Email us, or call **877-355-2760**, TTY: 711. We accept all relay calls.

