COBRA QUALIFYING EVENT

PLEASE COMPLETE ENTIRE FORM

Employer Name:
Division/Location:

Please mail, email or fax this request to:
COBRA-Advantage
43471 Ridge Park Dr Ste. A
Temecula, CA 92590
Toll Free: (877) 506-1660
Toll Free Fax: (877) 561-1661

PRINCIPAL QUALIFYING BENEFICIARY:

Last Name:	First Name:		Middle Initial:
Current Address:		Telephone #:	
City:		State:	Zip:
Social Security #:	Marital Status:	Date of Birth:	Gender:

QUALIFYING EVENT (QE) INFORMATION:

☐ Termination ☐ Death of covered Employee ☐ Cessation of dependency

☐ Reduction of hours ☐ Divorce or legal separation ☐ Medicare entitlement

Date of Qualifying Event: _____/_____/_____

Date Present Benefits Terminate: _____/_____/_____

Is this a Secondary Qualifying Event? ☐ Yes ☐ No

If Yes, original Qualifying Event date: _____/_____/_____

Hire Date:_____

Benefit Start Date:_____

CURRENT BENEFITS:

Benefit:	PLEASE INDICATE: CARRIER AND HMO-PPO-POS	Single and Rate	Emp+Spou And Rate	Emp+Child And Rate	FamilyAnd Rate
Medical Plan					
Dental Plan					
Vision Plan					
Other (EAP, etc.)					
Health Care FSA:	☐ Yes ☐ No If Yes, does the participant have a positive balance? Amount? $				

DEPENDENT INFORMATION:

Relationship	Name (Last, First, MI)	Date of Birth	Gender	SS#
Spouse:				
Child:				
Child:				
Child:				
Child:				

Submitted By: Date: Phone #:

COBRA-Advantage use only Date Entered: By: