HealthPlans
A HARVARD PILGRIM COMPANY

COBRA Qualifying Event Notification **EMPLOYER:** _____

TYPE OF QUALIFYING EVENT :

- ☐ QE1 Involuntary Termination of Employment (other than by reason of gross misconduct)
- ☐ QE2 Voluntary Termination of Employment (employee resignation)
- ☐ QE3 Reduction in Hours
- ☐ QE4 Divorce or Legal Separation of Covered Employee
- ☐ QE5 Dependent Child Ceasing to be a Dependent Under Plan's Terms
- ☐ QE6 Death of Covered Employee
- ☐ QE7 Covered Employee's Entitlement to Medicare Benefits
- ☐ QE8 Disabled Individual Who Has Sent Notice of His/Her Social Security Disability Determination

Eligible Members: ☐ Employee ☐ Dependent

Name: _____

Address: _____

_____

Social Security Number _____ / _____ / _____ Date of Birth _____ / _____ / _____

Last Date Employed _____ / _____ / _____

Coverage Termination Date
(last day covered under your Plan) _____ / _____ / _____

Is Employee Currently Covered by Medicare (Entitled) YES _____ NO _____

Covered Spouse:

Name: _____

Address: _____

_____

Social Security Number _____ - _____ - _____ Date of Birth _____ / _____ / _____

Covered Children:

Name: _____ Date of Birth _____ / _____ / _____

Name: _____ Date of Birth _____ / _____ / _____

Name: _____ Date of Birth _____ / _____ / _____

Benefits Currently In Force:	SINGLE	EMPLOYEE+SPOUSE	PARENT/CHILD	FAMILY
MEDICAL	_____	_____	_____	_____
DENTAL	_____	_____	_____	_____
VISION	_____	_____	_____	_____

SIGNATURE _____