

Gallagher Benefit Services

COBRA Continuation of Coverage Qualifying Event Notice

CLIENT NAME (Group and Unit): _____

This form is to be filled out when an employee or dependent of an employee loses health, dental and/or vision coverage due to a COBRA qualifying event. This form does not need to be completed in the event of a leave of absence (medical or family), workers' comp, or an employee voluntarily terminating his/her insurance.

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Date of Notice to GBS: _____

Gallagher Benefit Services
11 Midstate Drive, Suite 200
Auburn, MA 01501 cobra@gbs-consult.com
(800) 229-8008 x 117 / (508) 832-0491 fax

COBRA Qualifying Beneficiary (CQB) Information:

CQB Name: _____ CQB Date of Birth: _____

Employee Name: _____ CQB Gender: M F
If different than CQB Name

CQB Address: _____

CQB SS # _____ Email: _____

On _____, (date of event) the above CQB incurred the following Qualifying Event for purposes of COBRA continuation of coverage: (check one)

- | | |
|---|---|
| <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction of Hours (Reason: _____) <input type="checkbox"/> Employee's Medicare Entitlement | <input type="checkbox"/> Divorce or Legal Separation <input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Death of Employee |
|---|---|

| HEALTH COVERAGE | DENTAL COVERAGE | VISION COVERAGE |
|--|--|--|
| Plan Name: _____ | Plan Name: _____ | Plan Name: _____ |
| Group #: _____ | Group #: _____ | Group #: _____ |
| Subscriber #: _____ | Subscriber #: _____ | Subscriber: _____ |
| <input type="checkbox"/> Ind <input type="checkbox"/> Ind+1 <input type="checkbox"/> Fam | <input type="checkbox"/> Ind <input type="checkbox"/> Ind+1 <input type="checkbox"/> Fam | <input type="checkbox"/> Ind <input type="checkbox"/> Ind+1 <input type="checkbox"/> Fam |

Dependents on Plan, if any:

| Name | DOB | Relationship to Subscriber |
|------|-----|----------------------------|
| | | |
| | | |
| | | |
| | | |

Coverage for the CQB Will Terminate On: _____ (Date)

Submitted By: _____ Title: _____