QUALIFYING EVENT NOTIFICATION

Please complete and return to: COBRA@townebenefits.com or Fax (757) 631-6495

Employer Name: ____

Employee Name: ____

Employee personal email address: ______________________ Hire Date: __________

Social Security # ______________________ Date of Birth: ____________________

Phone #: ______________________ Gender: ______________________

Address: ____

City: __________________ State: ________________ Zip Code: __________

QUALIFYING EVENT DATE: __________ LAST DATE OF COVERAGE: __________

FIRST DATE OF COBRA: __________ LAST DATE OF COBRA: __________

QUALIFYING EVENT TYPE Please elect one of the following below

____Term. (Voluntary)	____ Term. (Involuntary)	____ Employee's Death
____ Retirement	____ Ineligible Dependent	____ Divorce
____ Reduced Hours	____ Leave of Absence	____ Employee's Medicare Entitlement
____ Loss of Eligibility	____ Bankruptcy	____ Reduction in Force
____ State Continuation	____ Work Stoppage	____ Termination with Severance
____ Retiree Bankruptcy	____ USERRA-Termination	____ USERRA-Reduction in Hours

BENEFIT PLANS:

Indicate the benefit plan, coverage level and total premium from carrier bill for the Qualified Beneficiary and all dependents covered:

Benefit Plan:	**Coverage Level:** (example: Employee, employee+Child,Employee+Spouse,Family)
HMO (plan name/cost): ______________	Coverage Level: ______________
PPO (plan name/cost): ______________	Coverage Level: ______________
Dental (plan name/cost): ______________	Coverage Level: ______________
Vision (plan name/cost): ______________	Coverage Level: ______________
FSA (plan name):______________	Coverage Level: ______________
HDHP (plan name): ______________	Coverage Level: ______________
HRA (plan name): ______________	Coverage Level: ______________
GAP (plan name): ______________	Coverage Level: ______________

Family Information (if currently covered):
Start Date: ___________________________

Spouse: ___________________________ M □ F □ D.O.B. ___________________ SS# ________________

Child: ____________________________ M □ F □ D.O.B. ___________________ SS# ________________

Child: ____________________________ M □ F □ D.O.B. ___________________ SS# ________________

Child: ____________________________ M □ F □ D.O.B. ___________________ SS# ________________

Child: ____________________________ M □ F □ D.O.B. ___________________ SS# ________________

Child: ____________________________ M □ F □ D.O.B. ___________________ SS# ________________

If Employee has a Severance Agreement:

Subsidy Schedule Start Date: ____

Subsidy Schedule End Date: ____

Subsidy Schedule Amount Type (Percentage or Flat Amount): ____________________

Amount: ____

Insurance Type: ____

FOR TAKEOVERS ONLY:

Initial Qualifying Event Notification Sent (mm/dd/yyyy): _________________________

Date Enrollment Form Received Back from Employee (mm/dd/yyyy): ________________

Currently Paid in Full Through (mm/dd/yyyy): __________________________________

Next Premium Owed (mm/dd/yyyy): ____