MNHG COBRA Continuation of Coverage
Qualifying Event Notice

MNHG Unit Name: _____

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.

Date of Notice to GBS: _____

GROUP BENEFITS STRATEGIES
11 MIDSTATE DRIVE, SUITE 200
AUBURN, MA 01501
(800) 229-8008 office / (508) 832-0491 fax

COBRA Qualifying Beneficiary (CQB) Information: (please print)

CQB Name: _____ CQB Date of Birth: ___/_____/_____

Employee Name: _____ CQB Gender: M___ F___
If different than CQB Name

CQB Address: _____
_____
_____

CQB SS# _____

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

- □ Termination of Employment
- □ Reduction of Hours (Reason: _____)
- □ Employee's Medicare Entitlement
- □ Divorce or Legal Separation
- □ Loss of Dependent Status
- □ Death of Employee

HEALTH COVERAGE	DENTAL COVERAGE	VISION COVERAGE
Plan Name:	Plan Name:	Plan Name:
Group #:	Group #:	Group #:
Subscriber #:	Subscriber #:	Subscriber:
□Ind □Ind+1 □Fam	□Ind □Ind+1 □Fam	□Ind □Ind+1 □Fam

Dependents on Plan, if any:

Name	DOB	Relationship to Subscriber

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

Submitted By: _____ Title: _____