# Group Benefits Strategies

COBRA Continuation of Coverage
Qualifying Event Notice

CLIENT NAME (Group and Unit): _____

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*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.*

*Termination for gross misconduct is not a qualifying event.*

Date of Notice to GBS: _____

Group Benefits Strategies
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)*

- ◯ 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: _____