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.

Termination for gross misconduct is not a qualifying event.

Date of Notice to GBS: _____

GBS - Gallagher Benefit Services
11 Midstate Drive, Suite 200
Auburn, MA 01501
Gretchen_Grogan@ajg.com
1(774) 321-3561 / (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: _____