

Gallagher Benefit Services

COBRA Continuation of Coverage Qualifying Event Notice CLIENT 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.

Termination for gross misconduct is not a qualifying event.

Gallagher Benefit Services
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1(774) 321-3561 / (508) 832-0491 fax

Date of Notice to GBS: _____

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

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

Dependents on Plan, if any:

Name	DOB	Relationship to Subscriber

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

Submitted By: _____ Title: _____