

COBRA NOTIFICATION FORM

Form must be completed in full to process.
Click SUBMIT at the end of this form to send by email,
or print and fax to Jill Polinski at 612.436.5602. Questions? 612.436.5631
Please allow a 5-day turnaround.

Please complete all areas that relate to this individual:

EMPLOYER	Name <input type="text"/>	Your Name <input type="text"/>
	Address <input type="text"/>	
	City <input type="text"/>	State <input type="text"/>
	Phone <input type="text"/>	Zip <input type="text"/>

EMPLOYEE OR DEPENDENT'S NAME & ADDRESS

Last Date of Employment <input type="text"/>	Date of Hire <input type="text"/>
Employee Name <input type="text"/>	Date of Birth <input type="text"/>
Address: <input type="text"/>	Soc. Sec. # <input type="text"/>
City <input type="text"/>	State <input type="text"/>
	Zip <input type="text"/>

Spouse & Children information required if covered under insurance plan

Spouse <input type="text"/>	Date of Birth <input type="text"/>
Number of Children <input type="text"/>	

QUALIFYING EVENT

- Involuntary Termination/ Layoff
- Voluntary termination
- Reduction of hours
- The covered employee becoming eligible for Medicare benefits
- Death of covered employee
- Disability of covered employee
- A covered dependent child ceasing to be an eligible dependent under the plan eligibility requirements

EMPLOYEE COUNT

Average number of employees working 20 or more hours in the past 12 months

CURRENT COVERAGE Please note the 2% admin fee is NOT included, must be added to totals by employer

<input type="checkbox"/> Employee Health	Type of coverage (click all that apply):	<input type="checkbox"/> Children
Insurance Company <input type="text"/>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse	Group Number <input type="text"/>
Premium \$ <input type="text"/>		
<input type="checkbox"/> Employee Dental	Type of coverage (click all that apply):	<input type="checkbox"/> Children
Insurance Company <input type="text"/>	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse	Group Number <input type="text"/>
Premium \$ <input type="text"/>		
<input type="checkbox"/> Employee Life	Type of Coverage (click all that apply):	
Insurance Company <input type="text"/>	<input type="checkbox"/> Employee	Group Number <input type="text"/>
Premium \$ <input type="text"/>		

SUBMIT Click this button to email this form to Jill Polinski: jpolinski@bearence.com