COBRA QUALIFYING EVENT FORM

For Employer Use

Group No.: ________________________ Group Termination Date: ______________

Employee Name: ___________________ Certificate No.________________________

Please Check Box for Qualifying Event

Employee losing coverage because of:

- ☐ Reduction in work hours
- ☐ Layoff for economic reasons
- ☐ Voluntary resignation
- ☐ Discharge other than for gross misconduct

Spouse/Dependents losing coverage because of:

- ☐ Surviving spouse or children of a deceased employee
- ☐ Worker becomes Medicare-eligible and, as a result, loses health coverage
- ☐ Dissolution of marriage
- ☐ Dependent no longer eligible as a dependent under health plan

Qualifying Event Date: _________________________________

Employer Signature: ___________________________________ Date: ____________

Person relaying information if other than employer: _____________________________