COBRA Notification of Qualifying Event

NATIONAL EMPLOYEES
HEALTH PLAN

Employer Information

Employer Name ______________________ Division/Location/Local ______________________

Contact Person ______________________ Phone No. ______________________

Qualified Beneficiary Information

The qualified beneficiary is the person the letter is going to: Employee _________ Dependent ________

If dependent, complete this section with the dependent's information i.e. The ex-spouse's in case of divorce or dependent child's if no longer being covered.

Last Name ______________________ First ______________________ Initial ________

Participant ID ______________________ Date of birth ______________________

Participant Address ______________________ City ______________ State ____ Zip _________

Marital Status Married ____ Single ___ Divorced ___ Gender Female ______ Male _______

Qualifying Event Date ______________________ Insurance Termination Date ______________________

Qualifying Event Code: ______________________

Please use the following codes: T = Termination, D = Death, L = Medical Leave, M = Medicare, R = Reduced Hours, S = Disability, V = Divorce, P = Dependent ceases top be covered, C = Loss of coverage/Laid off

Dependent Information

	Dependent Name	Relationship
Full Name	______________________	Spouse ____________
Full Name	______________________	Child ____________
Full Name	______________________	Child ____________
Full Name	______________________	Child ____________

Continuing Coverage Information

Benefit Type	**Insurance Carrier**	**Check Level of coverage for the participant(s) Indicate number of students if more than 1**			
		Single	Single + Children	Single+ Spouse	Family
Health					
Dental					
Vision					
Prescription					
FSA-Health Care Reimbursement		$_________ per month		$_________ per year	

Prepared by

______________________ ______________________

Printed name of preparer Signature of preparer / Date

This form must be completed by a representative of the employer. Please fax or email this completed form within 30 days of the qualifying event.

National Employees Health Plan • P.O. Box 430 • Sterling Heights, MI 48311
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