COBRA/RETIREE/PART-TIME NOTIFICATION FORM

( ) COBRA ( ) RETIREE ( ) PART-TIME ( ) NEW HIRE NOTICE

School District Name
Address
City, State & Zip
Phone # Ext. #

Is this Qualifying Event for the?
( ) Employee ( ) Dependent
Qualifying Event Date:___/___/___
Last day of Active/FT Cov.:___/___/__
Billing Effective Date:___/___/___

Effective Date:____/____/____

COBRA Qualifying Event that caused loss of coverage (check one).

Continuation of coverage for 18 months:
( ) Employee's retirement
( ) Employee's Resignation
( ) Employee's involuntary termination
( ) Employee's reduction of hours
( ) Employee's layoff
( ) Employee begins leave of absence

Continuation of coverage for 36 months:
( ) Divorce/legal separation
( ) Ineligibility of dependent child
( ) Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage.
( ) Death of covered employee/retiree
( ) Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceed-ings under Title 11 (bankruptcy) United States Code.

Employee Social Security Number:_____

Employee Name:_____
Address:_____
_____
Telephone Number:_____

Date of Birth:____/____/____ ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Current Employee Coverage
( ) Dental ( ) Vision ( ) Medical

Current Employee Level of Coverage:

1. ( ) Single 2. ( ) Single + 1 Child
3. ( ) Single + Children 4. ( ) Single + Spouse
5. ( ) Single + Children + Spouse

If Qualified Beneficiary is losing Medical Coverage (pre-COBRA), complete the following:

- Waiting Period (if any) Begin Date (If none, give Medical Coverage Begin Date here and below): Mo.___ Day___ Yr.____
- Medical Coverage Begin Date: Mo.___ Day___ Yr.___

Dependent Information: Note: Completion of this section is necessary. (Please complete only for spouse/dependent(s) losing Coverage.) Each name should include last, first and middle initial.

Name:_____
Relationship: ( ) Spouse ( ) Child
SSN:_____ Date of Birth:___ ___ ___
Waiting Period (if any) Begin Date (If none, give Medical Coverage Begin Date) ___/___/___
Medical Coverage Begin Date___/___/___

Name:_____
Relationship: ( ) Spouse ( ) Child
SSN:_____ Date of Birth:___ ___ ___
Waiting Period (if any) Begin Date (If none, give Medical Coverage Begin Date) ___/___/___
Medical Coverage Begin Date___/___/___

Name:_____
Relationship: ( ) Spouse ( ) Child
SSN:_____ Date of Birth:___ ___ ___
Waiting Period (if any) Begin Date (If none, give Medical Coverage Begin Date___/___/___
Medical Coverage Begin Date___/___/___

(Attach a separate sheet if additional names need to be listed.)

Group #

If the covered dependent(s) reside at a different address from the Qualified Beneficiary, please provide name and address:
(Attach a separate sheet if additional names need to be listed.)

Name(s): (last, first, mi)_____

Street:_____

City:_____ State:_____ Zip Code: _____

Indicate the appropriate Carrier Codes, Option and Status:
(Refer to your Rate Report and enter the current Carrier Code, Option, and Status for each coverage in effect.)

	Carrier Code	Div	Level of Coverage
Medical	_____	____	_____
Prescription	_____	____	_____
Dental	_____	____	_____
Vision	_____	____	_____
Opti-Vision	_____	____	_____
EAP Program	_____	____	_____

Prepared By: _____
Date Mo._____ Day_____ Yr._____
Phone # (__)_____. Fax # (__)_____.