

**EMPLOYER:**

Please complete the following table for the employee. All changes must be sent to COBRAssist, inc. within 30 days of the event. Please note that COVERAGE IN EFFECT AT TIME OF EVENT can include <b>Medical, Dental, Vision</b> , as well as <b>Health Flexible Spending Accounts</b> and <b>Health Reimbursement Arrangements</b>	
LAST, FIRST NAME	
SOCIAL SECURITY #	
DATE OF BIRTH	
ADDRESS	
COVERAGE IN EFFECT AT TIME OF EVENT	
PHONE NUMBER	
DATE OF HIRE	
FIRST DATE OF INSURANCE COVERAGE	

Complete a table for each dependent.	
LAST, FIRST NAME	
SOCIAL SECURITY #	
DATE OF BIRTH	
ADDRESS IF DIFFERENT	
COVERAGE IN EFFECT AT TIME OF EVENT	
RELATIONSHIP	
FIRST DATE OF INSURANCE COVERAGE	

LAST, FIRST NAME	
SOCIAL SECURITY #	
DATE OF BIRTH	
ADDRESS IF DIFFERENT	
COVERAGE IN EFFECT AT TIME OF EVENT	
RELATIONSHIP	
FIRST DATE OF INSURANCE COVERAGE	

LAST, FIRST NAME	
SOCIAL SECURITY #	
DATE OF BIRTH	
ADDRESS IF DIFFERENT	
COVERAGE IN EFFECT AT TIME OF EVENT	
RELATIONSHIP	
FIRST DATE OF INSURANCE COVERAGE	

Please indicate COBRA event and list the date of the event.			
<b>Events for sending General Notice to newly covered under Medical, Dental, Vision, Health FSA, HRA:</b>			
New Employee	Date _____	Adding New Dependents	Date _____
<b>Events for sending Event Notice to those experiencing COBRA event:</b>			
<b>Voluntary Termination</b> (18 mos.)	Date _____	Military Leave (24 mos.)	Date _____
<b>Involuntary Termination</b> (18 mos.)	Date _____	Retirement (18 months)	Date _____
Reduced Hours (18 mos.)	Date _____	Disability (29mos.)	Date _____
Ineligible Dependent (36 mos.)	Date _____	Divorce/Legal Separation (36 mos.)	Date _____
Death (36 mos.)	Date _____	End FMLA (18 mos.)	Date _____
COBRA STARTS	Date _____	Other	Date _____