



OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
 EMPLOYEES GROUP INSURANCE DIVISION
COBRA QUALIFYING EVENT NOTICE (Q. E. Notice)

To be completed by the insurance/benefits coordinator at the time of a
 COBRA Qualifying Event and sent to the Employees Group Insurance Division.

Employee name: _____ SSN: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Employer name: _____ Agency or group number: _____

Insurance/benefits coordinator name: _____

Insurance/benefits coordinator phone number: _____

Date: _____ Is the employee eligible to vest/retire? Yes* ___ No ___

***Insurance/benefits coordinator: If yes, explain the options of both vesting/retirement and COBRA so the member can make an informed choice.**

This employee and/or dependent(s) is entitled to continuation of coverage for the following reason (COBRA Qualifying Event):

___ Termination date**: _____

**Was employee terminated for gross misconduct? Yes ___ No ___

**Was employee called to military duty (USERRA)? Yes ___ No ___

___ Reduction of work hours - date: _____

___ Death date: _____

___ No longer an eligible dependent as of date***: _____

***Reason dependent is not eligible (**Required**): _____

Name and current mailing address of ineligible dependent(s):

