



COBRA Qualified Beneficiary Takeover Form

For any new employer group, we will need one of these for each existing COBRA Qualified Beneficiary.

Company Name: _____

Contact Person: _____ Phone: _____

Employee Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Marital Status: Single Married Widowed Divorced Gender: Male Female

Please list the names, social security numbers and birth dates for any other covered family members.

DEPENDENT NAME	SSN	BIRTH DATE	RELATIONSHIP

Qualifying Event Information

Qualifying Event Date: _____

Date Active Coverage Terminates: _____

Type of COBRA Event (check one)

- Involuntary Termination (fired, layoff, reduction in workforce)
- Voluntary Termination / Resignation / Retirement
- Reduction of Hours (full-time to part-time, unpaid leave of absence)
- Death of Employee (spouse and dependent children only)
- Divorce or Legal Separation (spouse and dependent children only)
- Loss of Dependent Status (dependent children only)

Has the qualified beneficiary been approved for an additional 11-month disability extension?

Yes No

At the time of the termination or reduction in hours, was the employee eligible to receive Social Security income?

Yes No

Has the employee had at least 18 months of previous group health plan coverage? Yes No

Current Qualifying Beneficiary Enrolled Benefits / Eligible Benefits

BENEFIT	CARRIER	TYPE (SINGLE, FAMILY, ETC.)	MONTHLY PREMIUM	ORIGINAL EFFECTIVE DATE

Medical HRA? Yes No

Medical FSA? Yes No Monthly Contribution Amount: _____

Date COBRA Notice was mailed: _____

Has an election been made? Yes No Date of Election: _____

Has primary payment been received? _____

Date Last Premium Paid: _____ Coverage Paid Through: _____

Monthly Subsidy (if applicable) _____ Length of Subsidy (if applicable) _____

Notes

Form Completed By: _____

Name (Print): _____

Date: _____ Phone: _____ Fax: _____

Signature: _____