EMPLOYER NOTIFICATION OF COBRA QUALIFYING EVENT

Employer: ______________________________ **Group #:** ______________________________

Employee: ______________________________ **Social Security #:** ______________________________

Spouse (if applicable): ____

Address: ____

City: ____________________________ **State:** ____________ **Zip Code:** __________________

QUALIFIED BENEFICIARY(S):

- ☐ Employee Only
- ☐ Spouse Only
- ☐ Family
- ☐ Spouse and Children
- ☐ Dependent Child(ren), Name: ____

COBRA QUALIFYING EVENT:

- ☐ Reduction in the employee's hours of employment.
- ☐ Termination of the employee's employment (for reasons other than gross misconduct).
- ☐ Death of the employee.
- ☐ End of the employee's marriage due to dissolution, annulment, divorce or legal separation.
- ☐ Employee becoming entitled to Medicare.
- ☐ Dependent child ceasing to be considered a dependent as defined in the plan.
- ☐ For retiree coverage only, termination or substantial elimination of retiree coverage within one year before or after filing Chapter 11 bankruptcy.

DATE OF QUALIFYING EVENT: ____

DATE COVERAGE TERMINATES: ____

COVERAGE TERMINATING:

☐ Medical ☐ Dental ☐ Rx Drug ☐ Vision

☐ Flex ☐ Other Health: ______________________

I hereby authorize Midwest Security Administrators, Inc. to offer COBRA Continuation under the employer's benefit plan(s), as stated above.

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Authorized Signature

Completed By: ______________________________ **Date:** __________________

Title: ______________________________

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