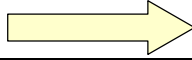


SECTION I. Employer Information

Employer Name _____



Administrator Name _____

SECTION II. Qualifying Event Information
 New Hire (Please complete a all Sections)

 Death of an Employee

 Employee's Medicare Entitlement

 Termination of Employment

 Divorce or legal Separation

 Reduction in hours of employment

 Loss of dependent Status

Qualifying Event Date _____

SECTION III. Employee Information

First Name _____ Last Name _____ DOB _____ SSN _____

Address _____

SECTION IV. Dependent Information

	<u>First Name</u>	<u>Last Name</u>	<u>DOB</u>	<u>SSN</u>
Spouse				
Child				
Child				
Child				
Child				

Address _____

SECTION V. Coverage Information
1. Please list the plan type, ie HMO, PPO, POS, etc.
2. Please list the original effective date below each coverage. This is required for the HIPAA certificate.

	<input type="checkbox"/> Medical Plan	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Employee Assistance Plan
----->1	Plan Type	Plan Type	Plan Type	<input type="checkbox"/> Flexible Spending Account
	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2	1. Annual Election
	Original Effective Date	Original Effective Date	Original Effective Date	2. Claims Paid
----->2				3. Payroll Deductions to date

As required under COBRA guidelines, please send the qualified beneficiary (and eligible dependents as applicable) the appropriate Election Notices and Forms for COBRA continuation coverage within 14 days of the receipt of this notice

Signature _____

Title _____

Date _____