MEDCOM *COBRA Plan Administration* Fax: 904.421.3642 Office: 904.596.4500 Toll Free: 800.523.7542	**ADMINISTRATION TAKEOVER** **CURRENT COBRA PARTICIPANTS** ***Complete this form for each (1) COBRA Participant; and, (2) Each Qualified Beneficiary Currently In Election Period*** **Employer:**

I. COBRA PARTICIPANT INFORMATION: LOCATION:______________________

Name________________________________ Social Security No.____________________ Date Birth____________

Address____________________________________City______________________ State_______ Zip___________

Phone (__)__________________________ Original Coverage Effective Date_________________ Sex ❍M ❍ F

II. NAMES OF DEPENDENTS ON COBRA:

Name	Date of Birth	Social Security No	Relationship	Event Reason

III. EMPLOYEE'S NAME (If person in "I" above is a dependent)

Name________________________________ Social Security No.____________________ Date Birth____________

IV. QUALIFYING EVENT

EVENT DATE_____________________ **DATE NOTICE MAILED**__________________

EVENT REASON: ❍**1. Termination** ❍**4. Death** ❍**7. Divorce/Separation**

❍**2. Retirement** ❍**5. Ineligible Dependent** ❍ **8. Loss of Coverage**

❍**3. Medicare** ❍**6. Reduced Hours**

COBRA COVERAGE PAID TO DATE ________________/_____________/______________

V. LEVEL OF COVERAGE/PLANS (Confirm plan enrollment and enter premium for level of coverage):

	MEDICAL ❑YES ❑NO	DENTAL ❍YES ❍NO	VISION ❍YES ❍NO
Employee	$	$	$
EE + Spouse	$	$	$
EE + Child	$	$	$
EE + Family	$	$	$

VI. Employer's Confirmation

Employer Signature____ Date___________________________________

Form Name RETRO COBRA.doc; Ed 10/00