

**Qualifying Event
Notification
Form**

EBC Only

EBC Group ID Number

EBC Specialist

Processed Date

Web Address:
www.ebcflx.com

U. S. Mail:
Employee Benefits Corporation
COBRASecure
PO Box 44347
Madison WI 53744-4347

Phone:
Monday - Friday, 8:00 - 5:00 CST
608 831 8445
800 346 2126

Fax:
608 831 4790

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Employee Benefits Corporation

302-8 04/06

Group ID Number _____ Company Name _____ Date (mm/dd/yyyy) _____
() _____
Division Name _____ Telephone _____

Primary Qualified Beneficiary (QB) information

The primary qualified beneficiary (QB) is (a) the covered employee in the event of termination or reduction in hours; (b) the spouse/ex-spouse in the event of divorce, legal separation, employee's death, or Medicare entitlement; or (c) the dependent child in the event the child's single parent/employee dies, or in the event the child otherwise ceases to be an eligible dependent under the plan due to age, student status, etc.

First Name of Primary QB _____ Middle Initial _____ Last Name _____
Home Address _____ City _____ State _____ Zip _____
() _____ | | | - | | - | | | | |
Home Phone _____ Social Security Number _____
/ / / / /

Birth Date (mm/dd/yyyy) _____ Gender M | F _____ Date Hired (mm/dd/yyyy) _____
Primary QB Is: Covered Employee Spouse/Ex-Spouse Dependent/Ex-Dependent

If the primary QB is the spouse or dependent, complete the following information for the covered employee:

Name _____ Date Hired (mm/dd/yyyy) _____ Social Security Number _____
/ / / / /

Event information

Qualifying Event: Termination Reduction in Hours Divorce/Legal Separation Death of Employee
 Loss of Dependent Status Entitlement to Medicare

Date of Qualifying Event _____ Last Day of Plan Coverage _____ (mm/dd/yyyy) _____
 Offer Qualified Beneficiary Retiree/Alternative Benefit Plan Check if employee has more than 18 mo. continuous coverage under the group plan

Coverage information

	Premium Amount and Coverage Level (Coverage level can be Single, Employee plus one, Employee and spouse, Employee and one child, Employee and children, Family)	Coverage Plan Type (For example, HMO, PPO)	Original Effective Date of Coverage
<input type="checkbox"/> Health Insurance:	_____	_____	_____
<input type="checkbox"/> Dental Insurance:	_____	_____	_____
<input type="checkbox"/> Vision Insurance:	_____	_____	_____
<input type="checkbox"/> Health Care FSA:	_____	_____	_____
<input type="checkbox"/> HRA:	_____	_____	_____
<input type="checkbox"/> EAP:	_____	_____	_____
<input type="checkbox"/> Other Insurance:	_____	_____	_____

Secondary Beneficiary information

Names of Secondary Beneficiaries	Relationship (spouse, son, daughter)	SSN	Date of Birth
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Please indicate if spouse or dependent(s) reside at a different address:

Spouse Dependent(s)

Spouse Home Address _____ City _____ State | Zip _____ Spouse Telephone _____

Dependent Home Address _____ City _____ State | Zip _____ Spouse Telephone _____

Dependent Home Address _____ City _____ State | Zip _____ Spouse Telephone _____

Don't forget to contact the insurance company to notify them of a change in coverage upon completion of this form