

**COBRA
Qualifying Event/
Termination
Form**

Use to notify us of a COBRA Qualifying Event and the simultaneous BESTflex Plan or EBC HRA termination

1

EBC Only

EBC Group ID Number

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

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

Primary Qualified Beneficiary (Primary QB) information

This section of the form directs who should be offered COBRA continuation coverage based on the COBRA event (i.e. termination of employment or divorce).

This person (Primary QB) is: Covered Employee Spouse/Ex-Spouse Dependent/Ex-Dependent

First Name of Primary QB _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip _____

Birth Date (mm/dd/yyyy) _____ Social Security Number _____ Gender M | F _____ Home Phone _____

If you have checked either spouse or dependent above, please complete the information below regarding your active employee:

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

Select the event that caused the loss of coverage:

Termination Reduction in Hours Divorce/Legal Separation _____ / _____ / _____
 Death of Employee Loss of Dependent Status Entitlement to Medicare **Date of Qualifying Event**
 (mm/dd/yyyy)

Voluntary drop of coverage is not a Qualifying Event; Entitlement to Medicare Note: a Qualifying Event occurs only if coverage is dropped by the policy due to an employee reaching a certain age.

Coverage information

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, Dean HMO, UHC Plan 2, BCBS POS)	Effective Date of Coverage (mm/dd/yyyy)	Last Day of Plan Coverage (mm/dd/yyyy)
<input type="checkbox"/> Health Insurance: _____	_____	_____ / _____ / _____	_____ / _____ / _____
<input type="checkbox"/> Dental Insurance: _____	_____	_____ / _____ / _____	_____ / _____ / _____
<input type="checkbox"/> Vision Insurance: _____	_____	_____ / _____ / _____	_____ / _____ / _____
<input type="checkbox"/> Health Care FSA*: _____	_____	_____ / _____ / _____	_____ / _____ / _____

If the Primary QB was enrolled in the BESTflex Plan, you must complete Page 2 of this form

<input type="checkbox"/> HRA**:	_____	_____	_____ / _____ / _____	_____ / _____ / _____
<input type="checkbox"/> EAP:	_____	_____	_____ / _____ / _____	_____ / _____ / _____
<input type="checkbox"/> Other Insurance:	_____	_____	_____ / _____ / _____	_____ / _____ / _____

* The monthly BESTflex Plan Health Care FSA premium is calculated as follows: Plan year election amount – contributions to date + months left in the plan year = COBRA monthly premium (COBRA will not be offered to overspent accounts unless otherwise noted) ** If your HRA is attached to your health insurance, do not list this premium separately; you will still need to check the HRA box in this section.

Secondary Beneficiary information

Complete the Secondary Beneficiary information below if: (1) you have a spouse or dependent(s) covered under the group health plan and your rates are age-rated (this information is required to offer COBRA to beneficiaries) or (2) Employee Benefits Corporation provides HIPAA Certificates of Creditable Coverage as part of your plan. You do NOT have to complete Secondary Beneficiary information if you have tiered rates based on single, family, etc. coverage groups and Employee Benefits Corporation does not provide HIPAA Certificates of Creditable Coverage.

Names of Secondary Beneficiaries	Relationship (spouse, son, daughter)	Date of Birth (mm/dd/yyyy)
_____	_____	_____ / _____ / _____
_____	_____	_____ / _____ / _____
_____	_____	_____ / _____ / _____

Please complete below if spouse or dependent(s) were covered under the Group Health Plan and reside at a different address:

Spouse's Name _____
 Spouse Home Address _____ City _____ State | Zip _____ Spouse Telephone _____

Dependent's Name _____
 Dependent Home Address _____ City _____ State | Zip _____ Dependent Telephone _____

Dependent's Name _____
 Dependent Home Address _____ City _____ State | Zip _____ Dependent Telephone _____

We must receive this form within 30 days of a termination, reduction in hours, death of employee, or medicare entitlement; we must receive this form within 60 days of a divorce, legal separation or loss of dependent status

Spending Account information

Section 1: For this employee in this Plan Year, Employer records show that the Employer **withheld** the following amounts:

\$ _____ / ____ / ____
 Total amount withheld for the BESTflex Plan Health Care FSA * Date of last FSA payroll deduction (mm/dd/yyyy)

\$ _____ / ____ / ____
 Total amount withheld for the BESTflex Plan Dependent Care FSA Date of last FSA payroll deduction (mm/dd/yyyy)

* The Employee has 90 days from the termination date to submit claims with dates of service prior to the termination date.

Note: The total amount withheld for each FSA is not the employee's full, annual election, but the amount that was actually withheld from the employee's pay through their last payroll cycle.

I understand that my plan year ends on my termination date. If I am enrolled in the Health Care FSA or the Health Reimbursement Arrangement I have 90 days to submit claims for expenses that I incurred prior to my termination date.

_____/_____/_____
 Employee signature Date (mm/dd/yyyy)

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For Employee Benefit Corporation's Use:

Employee Name | | | - | | - | | | | |
 SSN

Client Name ORG ID
 / /

Event Date of Event (mm/dd/yyyy)

FSA / /
 Last day of coverage (mm/dd/yyyy)

HRA / /
 Last day of coverage (mm/dd/yyyy)