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# Notice of Qualifying Event Form

(to be filled out by the employer)

## Completion of This Form Authorizes Us To Send Out a Notice of Rights for COBRA Coverage

**Group Name:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

Employee Name: _____	
Employee Address: _____ _____	
SSN or Alt ID#: _____	Date of Qualifying Event: _____
Last Day of Coverage: _____	COBRA Start Date: _____

**The following qualifying event has occurred or will occur for the person identified above.  
 Check one:**

- End of employment
- Reduction of hours
- Retirement
- Death of covered employee
- Divorce or legal separation **(list name of spouse and children losing coverage below)**
- Child's loss of dependent status **(list child's name below)**

Name of Spouse or Child: _____
Address (if different): _____ _____

Completed by: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_