COBRA Qualifying Event Notification — Takeover

**Notifications must be received by the 15th of the month if administration is to begin on the first day of the following month.*

Client Name _____ Client ID# _____

Branch Name (if applicable) _____ Submitted by _____

PERSONAL INFORMATION

Employee's Name (Last, First, MI) _____ Gender ☐M ☐F

Participant Name (If different than Employee) _____ Gender ☐M ☐F

Address _____
Street City State Zip

DOB _____ SSN _____ Marital Status ☐S ☐M Date of Hire _____
(Only needed if Participant was an employee.)

Participant Email Addresss (if known) _____ Home Phone Number _____

QUALIFYING EVENT INFORMATION

If the above is a current COBRA enrollee, please provide:

1) Qualifying Event Date _____ 2) Date initial COBRA enrollment kit sent _____

3) COBRA Start Date _____ **4) Date premium paid to** _____
("Paid to" date will equal Plan Start Date unless premiums have been paid into the future.)

Select one of the following QE Types:

☐ Involuntary termination of employment
☐ Voluntary termination of employment
☐ Cessation of dependent status
☐ Reduction in hours of employment
☐ Divorce or legal separation from employee
☐ Start of bankruptcy proceeding by employer
☐ Death of employee
☐ Employee's Medicare entitlement

PRESENT PLAN BENEFITS INFORMATION

Original Effective Date of: Health _____ Dental _____ Vision _____

Indicate the level of coverage for each Plan the Participant is enrolled in currently.

Coverage Type	Name and Option of Benefit Plan (e.g. PPO or HMO if applicable)	PQB Only	PQB and Spouse	PQB and 1 Child	PQB and Family	PQB and Children
Health						
Dental						
Vision						
Other						

FSA Annual Election Amount _____ Claims Paid To Date _____

Employee Contribution _____ FSA Plan Year End Date _____

DEPENDENT INFORMATION

List the name (Last, First, MI) of all dependents covered as of the Participant's Qualifying Event date.

Spouse_____ DOB_____ SSN_____ Gender ☐M ☐F

Child_____ DOB_____ SSN_____ Gender ☐M ☐F

Child_____ DOB_____ SSN_____ Gender ☐M ☐F

Child_____ DOB_____ SSN_____ Gender ☐M ☐F

Child_____ DOB_____ SSN_____ Gender ☐M ☐F

For TASC Office Use Only: Entered by _____ Date Entered _____

Please return the completed form(s) to:

TASC • 2302 International Lane • Madison, WI 53704-3140 • 1-800-422-4661 • Fax: 608-663-2753 • www.tasconline.com