

# COBRA/Retiree Qualifying Event Notification Form

## How to File

To be completed by Employer.

Form can be submitted by (1) e-mail, (2) fax or (3) SFTP.

To submit by e-mail, to COBRA Print Form and sign. E-mail form to COBRAdivision@flex-admin.com  
to RETIREE Print Form and sign. E-mail form to RETIREEdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by SFTP, post to your SFTP folder at <https://securefile.flex-admin.com/>

## Qualifying Beneficiary (Employee or dependent eligible for Continuation of Benefits)

Employers Name\*:  \* Required Field

Name:    
Print name Social Security #

Mailing Address

City State Zip Code

D.O.B.  Gender:  Date of Hire:   
Male or Female

Phone Number:    
Home Phone Alternate Phone

## Employee's Information\* \*(if different from Qualifying Beneficiary)

Name:   
Print name

## Qualifying Event

### Type

Please select one:    
(Termination/Retirement/Reduced Hours/Divorce/Legal Separation/Employee's Death/Ineligible Dependent Employee's Medicare Entitlement/Loss of Coverage) Loss of coverage explanation

### Date

Original Qualifying Event Date (ie. last day of employment, date of death, etc.):

Retirement Date:

Loss of Coverage Date (effective date when insurance carrier terminated coverage):

Medicare Entitlement Date (date employee enrolled in medicare):

For loss of dependent status event only, loss of coverage date:

Department/Division

### Benefit Plans & Coverage Level

Retiree       COBRA

	Benefits	Carrier & Plan Name	Initial Coverage Began	Coverage Level (member, spouse, mem&sp, mem&child, mem&children, mem&family)
<input type="checkbox"/>	Medical			
<input type="checkbox"/>	Dental			
<input type="checkbox"/>	Vision			
<input type="checkbox"/>	EAP			
<input type="checkbox"/>	FSA			
<input type="checkbox"/>	Other <input type="text"/>			

Last FSA Payroll deduction date:

If the primary Qualified Beneficiary was enrolled in the Flexible Spending Account, they must have a positive balance at the time of termination to continue participation.

**For Takeovers Only**

Is the Qualifying Beneficiary Currently Enrolled?  Yes or No      COBRA Premium Paid Through Date:

### Dependent Information

Name (First, Last)	D.O.B.	Gender (Male or Female)	SS Number	Relationship (Spouse/Domestic Partner or Child)

Comments