COBRA Notification of New Hire, Termination Or Other Qualifying Event

Please Select One:
- ❑ New Hire – needs Initial Notification
- ❑ COBRA Qualifying Event

Instructions: Please complete and return this form within 30 days of an event to The Employers Association, attention COBRA Services Department. You may fax to 704-944-6076 or you may mail it to 3020 W. Arrowood Road, Charlotte, NC 28273.

Part I: Employee Data

Last Name	First Name	MI	Social Security Number	Gender
Mailing Address				
Date of Birth	Date of Hire	Date Coverage Effective	Date of Qualifying Event	
Describe the Type of Qualifying Event (i.e., Termination, Divorce/Legal Separation, etc.):				
Did employee provide a HIPAA certificate from their prior employer? No ❑ Yes ❑ (If "Yes", please attach a copy of the certificate.)				
Type of coverage: ❑ Medical/ Plan Type: _______	❑ Dental	❑Vision	❑ Medical FSA	
If covered by Medical FSA: Benefit amount available : $____________	Monthly Contribution amount: $_____________			

Part II: Dependent Data

(If more than 5 dependents, please complete the same information on a separate sheet of paper, then attach to this form.)

Dependent Last Name	First Name	MI	Social Security Number	Gender
Mailing Address (if different from that of employee)				
Date of Birth	Relationship to Employee	Coverage Effective Date (include copy of HIPAA certificate, if applicable)		
Type of coverage: ❑ Medical	❑ Dental	❑Vision		

Dependent Last Name	First Name	MI	Social Security Number	Gender
Mailing Address (if different from that of employee)				
Date of Birth	Relationship to Employee	Coverage Effective Date (include copy of HIPAA certificate, if applicable)		
Type of coverage: ❑ Medical	❑ Dental	❑Vision		

Dependent Last Name	First Name	MI	Social Security Number	Gender
Mailing Address (if different from that of employee)				
Date of Birth	Relationship to Employee	Coverage Effective Date (include copy of HIPAA certificate, if applicable)		
Type of coverage: ❑ Medical	❑ Dental	❑Vision		

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Type of coverage: ❑ Medical ❑ Dental ❑Vision				

Dependent Last Name	First Name	MI	Social Security Number	Gender
Mailing Address (if different from that of employee)				
Date of Birth	Relationship to Employee	Coverage Effective Date (include copy of HIPAA certificate, if applicable)		
Type of coverage: ❑ Medical ❑ Dental ❑Vision				

Part IV: Comments

Part V: Employer Data

Name and Title of Authorized Company Representative:	
Your Signature:	Date:
Company Name:	
Phone Number:	Fax Number:
E-mail Address:	