COBRA Qualifying Event Notification Form

Step 1: Qualified Beneficiary Information

*=Required Fields

*Employer Name (Do not abbreviate)

*Birth Date (mm/dd/yyyy)

*Participant Name (First, MI, Last)

*Social Security Number

☐ Male ☐ Female

*Participant Mailing Address

*Hire Date (mm/dd/yyyy)

*Benefits Effective Date (mm/dd/yyyy)

*City

*State

*Zip

Step 2: Spouse and Dependent Information

	*Name (Last, First)	*Date of Birth	*Social Security Number
Spouse:			
Dependent:			
Dependent:			
Dependent:			

Step 3: Benefit Information

Carrier Name	Plan Name	Plan Type (Medical/Dental)	Level of Coverage	Premium
				$
				$
				$
				$

Step 4: Event Details

Event Date: _____/_____/_____

☐ Initial Notice (New Hire)

Employee Qualifying Events:

☐ Termination
☐ Retirement
☐ Loss of Eligibility
☐ Other: _____

Dependent Qualifying Events*:

☐ Ineligible Dependent- Aged off Plan
☐ Divorce/ Separation
☐ Other: _____

***If the QB is a spouse/dependent, provide the Employee's name: _____**

Step 5: Authorization

I hereby state that to the best of my knowledge the above information is correct.

SIGNATURE OF EMPLOYER REPRESENTATIVE:_____ **DATE:**_____

Please fax this completed form to Pro-Flex Administrators, LLC: 716-929-2013 or toll free 1-855-214-8987
Or Email to: csr@proflextpa.com
Or mail to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221