FAX

COBRA QE REQUEST

BENEFITHelp Solutions

DATE: _____ **REQUEST #** _____ **OF** _____

TO: BenefitHelp Solutions COBRA

FAX: 888-393-2943 or 503-765-3453 **TEL:** 800-556-3137 or 503-765-3581

E-MAIL: _____

FROM: _____

COMPANY: _____

FAX: _____ **TEL:** _____

Please send a **COBRA Election Notice** as indicated below

Qualified Beneficiary Information:

Client Name: _____ **Client Division:** _____

First Name: _____ **Last Name:** _____

Mailing Address: _____

Social Security Number: - - **Gender:** M / F **D.O.B:** _____

Qualifying Event Information:

Qualifying Event Type (*Please check one*):

- ☐ **Involuntary Termination**
- ☐ **Voluntary Termination**
- ☐ **Reduction in Hours**
- ☐ **Leave of Absence**
- ☐ **Divorce ***
- ☐ **Ineligible Dependent ***
- ☐ **Death of Employee ***
- ☐ **Other:** _____

Date of Qualifying Event: _____

Original Coverage Effective Date: _____

Date Coverage Ends: _____

*** Please fill out additional information in this box if the Qualified Beneficiary experienced one of the indicated Qualifying Events**

Employee's Name: _____

SSN: _____ **DOB:** _____

Notes: _____

Qualified Beneficiary Plans:

Plan type	Plan Name	Family Tier
MEDICAL		
DENTAL		
VISION		
FSA / HRA / EAP		

Qualified Beneficiary *Dependent* Information:

Please complete the below as applicable for each Dependent

Name	SSN	DOB	Gender	Relationship