

# FAX

## COBRA QE REQUEST



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: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: M / F D.O.B: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

### 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 |
|------|-----|-----|--------|--------------|
|      |     |     |        |              |
|      |     |     |        |              |
|      |     |     |        |              |
|      |     |     |        |              |

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