

# FAX

## COBRA The Temporary Extension Act Notification



The Temporary Extension Act of 2010 allows employees to receive the ARRA subsidy if they first lost group coverage due to a reduction in hours and then were involuntarily terminated from employment.

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:

#### Requirements:

- 1.) Employee needs to have experienced a loss of coverage effective September 1, 2008 or later due to a reduction of hours.
- 2.) Employee was involuntarily terminated between March 2, 2010 - March 31, 2010.

Original Coverage Effective Date: \_\_\_\_\_

Date When Reduction of Hours Began: \_\_\_\_\_

Original Coverage End Date: \_\_\_\_\_

Date of Involuntary Termination: \_\_\_\_\_

### 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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