COBRA Notification Form

Professional Benefit Services, Inc.
Affordable administration of employee benefit plans

Employer

Preparer's Name | Preparer's Email Address | Phone Number | Date

☐ **New Enrollment** ☐ **Termination of Coverage** ☐ **Change of Address**

EMPLOYEE INFORMATION

Last Name | First Name | M.I

Mailing Address | City | State | Zip Code

☐ M ☐ F

Social Security Number | Date of Birth | Date of Hire

Email Address | Phone Number

TYPE OF QUALIFYING EVENT

☐ Termination ☐ Involuntary Termination ☐ Reduction in Hours ☐ Medicare Entitlement ☐ Loss of Dependent Status

☐ Retirement ☐ Divorce/Legal Separation ☐ Leave of Absence ☐ Military Service ☐ Death of Employee

Qualifying Event Date (Termination date) | Date Insurance Began | Date Active Insurance Ends

INSURANCE COVERAGE

Name Of Insurer	Monthly Premium	Employee Only	Employee + Spouse	Employee + Family	Employee + Child	Other
Medical:		☐	☐	☐	☐	
Dental:		☐	☐	☐	☐	
Vision:		☐	☐	☐	☐	
Other:		☐	☐	☐	☐	
Health Reimbursement Arrangement (HRA)		☐	☐	☐	☐	
Flexible Spending Account (FSA):	Annual Election	Contributed YTD		Annual Disbursements YTD		COBRA Eligible Unknown

DEPENDENTS

Covered Dependent Name	Address (if different)	Gender M/F	Last 4 SSN	Date of Birth	Benefits Start Date (only if different)	Relationship to Employee
		Female				
		Female				
		Female				
		Female				
		Female				

Will Employer Pay COBRA premuim as part of severance package ○ Yes ◉ No

If "Yes", COBRA premium will be paid to: ☐ PBS ☐ Insurance Carrier ☐ Payment End Date: _____

Other Notes: _____

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