



PBS

Professional Benefit Services, Inc.

COBRA Notification Form

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:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Health Reimbursement Arrangement (HRA)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flexible Spending Account (FSA):	Annual Election	Contributed YTD		Annual Disbursements YTD		COBRA Eligible

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

Will Employer Pay COBRA premium as part of severance package Yes No

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

Other Notes: _____

Professional Benefit Services, Inc.

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