COBRA Employee Information Form

Company Name _____ **Department (if applicable)** _____ **Current Date** _____

1 Employee Information

Last Name			First name
Date of Birth	Date of Hire	Social Security Number	Gender ☐ Male ☐ Female ☐ Other
Address			City, State, Zip
Phone Number			Email Address

2 Dependent Information (If any dependents live at a different address, please write which dependent(s) and add the other address in the notes section below.)

Date of Birth	Dependent Name	Relation	Dependent Social Security Number	Gender
____ ____ ____				☐ Male ☐ Female ☐ Other
____ ____ ____				☐ Male ☐ Female ☐ Other
____ ____ ____				☐ Male ☐ Female ☐ Other
____ ____ ____				☐ Male ☐ Female ☐ Other
____ ____ ____				☐ Male ☐ Female ☐ Other

Notes: _____

3 Employee Status

Is this a New enrollee in your Group Insurance Plan or terminated employee? ☐ New Enrollee ☐ Loss of Coverage

IF THIS IS A NEW ENROLLEE ON YOUR GROUP INSURANCE STOP HERE

4 Event Information

Event Date	Qualifying Event Reason:
Coverage End Date	☐ Termination – Involuntary ☐ Termination – Voluntary ☐ Reduction of Hours ☐ Divorce / Legal Separation ☐ Death ☐ Loss of dependent status ☐ Involuntary of coverage due to Medicare
Employer Subsidy ☐ Yes ☐ No Amount / % _____ End Date _____	

5 Benefit Information

Plan Type	Carrier & Plan Name *(Blue Cross HMO, Etc.)*	Coverage Level	Premium Amount
		☐ Single ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family	$
		☐ Single ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family	$
		☐ Single ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family	$
		☐ Single ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family	$
		☐ Single ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family	$

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