

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: _____

Date Coverage Ends: _____

* Please complete the additional information below 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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