



OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
 EMPLOYEES GROUP INSURANCE DIVISION
COBRA QUALIFYING EVENT NOTICE (Q. E. Notice)

To be completed by the insurance/benefits coordinator at the time of a
 COBRA Qualifying Event and sent to the Employees Group Insurance Division.

Employee name _____ SSN _____

Mailing address _____ City _____ State _____ Zip _____

Employer name _____ Agency or group number _____

Insurance/benefits coordinator name _____

Insurance/benefits coordinator phone number _____

Date _____ Is the employee eligible to vest/retire? Yes* No

****Insurance/benefits coordinator: If yes, explain the options of both vesting/retirement and COBRA so the member can make an informed choice.***

This employee and/or dependent(s) is entitled to continuation of coverage for the following reason (COBRA qualifying event):

Termination date** _____ Last day of employee insurance coverage _____

 **Was employee terminated for gross misconduct? Yes No

 **Was employee called to military duty (USERRA)? Yes No

Reduction of work hours - date _____

Death date _____

No longer an eligible dependent as of date*** _____

 ***Reason dependent is not eligible (**Required**) _____

Name and current mailing address of ineligible dependent(s):
