

# Notice of Qualifying Event

**Discovery Benefits**  
COBRA

Employer  Date of Qualifying Event  -  -

## 1. Employee Information

Employee Name (First, Middle Initial, Last)  Female  Male   
Date of Birth  -  -  Hire Date  -  -  Social Security Number  -  -   
Address  Phone  -  -   
City  State  Zip

## 2. Current Benefits

<input type="checkbox"/> <b>Health</b>	<input type="checkbox"/> <b>Dental</b>	<input type="checkbox"/> <b>Vision</b>
Carrier Name <input type="text"/>	Carrier Name <input type="text"/>	Carrier Name <input type="text"/>
Plan Description <input type="text"/>	Plan Description <input type="text"/>	Plan Description <input type="text"/>
Coverage Level <input type="text"/>	Coverage Level <input type="text"/>	Coverage Level <input type="text"/>
Last Date of Coverage <input type="text"/>	Last Date of Coverage <input type="text"/>	Last Date of Coverage <input type="text"/>
More than 18 Months Continuous Coverage** <input type="checkbox"/> YES <input type="checkbox"/> NO	More than 18 Months Continuous Coverage** <input type="checkbox"/> YES <input type="checkbox"/> NO	More than 18 Months Continuous Coverage** <input type="checkbox"/> YES <input type="checkbox"/> NO
If NO, initial date of coverage for this benefit** <input type="text"/>	If NO, initial date of coverage for this benefit** <input type="text"/>	If NO, initial date of coverage for this benefit** <input type="text"/>
<input type="checkbox"/> <b>Medical Spending Account</b>	<input type="checkbox"/> <b>Other Health Plan</b>	<input type="checkbox"/> <b>Life Insurance</b>
Annual Election \$ <input type="text"/>	Carrier Name <input type="text"/>	Face Amount \$ <input type="text"/>
Benefit Last Date of Coverage <input type="text"/>	Plan Description <input type="text"/>	Premium Amount \$ <input type="text"/>
Plan Year Start Date <input type="text"/>	Coverage Level <input type="text"/>	Last Date of Coverage <input type="text"/>
Plan Year End Date <input type="text"/>	Last Date of Coverage <input type="text"/>	Initial Date of Coverage <input type="text"/>
Account Paid Through Date <input type="text"/>	More than 18 Months of Continuous Coverage** <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Medicare Coverage</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
Year-to-Date Deduction Amount <input type="text"/>	If NO, initial date of coverage for this benefit** <input type="text"/>	If YES, Medicare coverage effective date <input type="text"/>

**\*\*HIPAA requires this information be provided on the Certificate of Coverage. This information must be included on this form to ensure compliance with HIPAA.**

## 3. Other Qualified Beneficiary Data (covered family members) (Required)

Spouse Name (First, Middle Initial, Last)   
Date of Birth  -  -  Social Security Number  -  -   
Address (If different from above)  Phone  -  -   
City  State  Zip

Children(s) Name(s) (required for Certificates of Coverage. Please attach sheet for additional dependents.)

Dependent(s) Name	Relationship	Social Security Number	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 4. Qualifying Event

<input type="checkbox"/> <b>Employee (EE):</b>	<input type="checkbox"/> Voluntary Termination*	<input type="checkbox"/> Reduction in Hours	<input type="checkbox"/> <b>Spouse/Dependent:</b>	<input type="checkbox"/> Death of Covered Employee	<input type="checkbox"/> Divorce
<input type="checkbox"/> Involuntary Termination*	<input type="checkbox"/> Employer's Bankruptcy (Retirees Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Covered by Medicare	<input type="checkbox"/> Legal Separation	
<input type="checkbox"/> Medical Leave of Absence (FMLA)			<input type="checkbox"/> Child Losing Dependent Status		
<input type="checkbox"/> Reservist called to Active Duty					
<input type="checkbox"/> <b>Notice of Unavailability:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No, If YES, Indicate Reason <input type="text"/>		<input type="checkbox"/> Termination prior to active benefit(s)		
<input type="checkbox"/> Gross Misconduct*	<input type="checkbox"/> Late Notice		<input type="checkbox"/> Other, please explain: <input type="text"/>		

\*Please note: Termination due to gross misconduct makes an employee and family members ineligible for COBRA coverage. If termination is due to gross misconduct, please document the reason for gross misconduct in a separate letter to Discovery Benefits and attach to this form.

## 5. Employer Representative Authorization

Employer Representative  Date  Phone