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

Health

Carrier Name
Plan Description
Coverage Level
Last Date of Coverage
More than 18 Months Continuous Coverage** | YES | NO
If NO, initial date of coverage for this benefit**

Dental

Carrier Name
Plan Description
Coverage Level
Last Date of Coverage
More than 18 Months Continuous Coverage** | YES | NO
If NO, initial date of coverage for this benefit**

Vision

Carrier Name
Plan Description
Coverage Level
Last Date of Coverage
More than 18 Months of Continuous Coverage** | YES | NO
If NO, initial date of coverage for this benefit**

Medical Spending Account

Annual Election $
Benefit Last Date of Coverage
Plan Year Start Date
Plan Year End Date

Other Health Plan

Carrier Name
Plan Description
Coverage Level
Last Date of Coverage
More than 18 Months of Continuous Coverage** | YES | NO
If NO, initial date of coverage for this benefit**

Life Insurance

Face Amount $
Premium Amount $
Last Date of Coverage
Initial Date of Coverage
Medicare Coverage | YES | NO
If YES, Medicare coverage effective date

****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

4. Qualifying Event

Employee (EE):

- Voluntary Termination*
- Reduction in Hours
- Involuntary Termination*
- Employer's Bankruptcy (Retirees Only)
- Medical Leave of Absence (FMLA) — Yes / No
- Reservist called to Active Duty

Notice of Unavailability: Yes / No, If YES, Indicate Reason

- Gross Misconduct*
- Late Notice

Spouse/Dependent:

- Death of Covered Employee
- Divorce
- Employee Covered by Medicare
- Legal Separation
- Child Losing Dependent Status
- Termination prior to active benefit(s)
- Other, please explain:

***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