HRC TOTAL SOLUTIONS
HR•Payroll•FSA•HRA•HSA•Commuter•COBRA

# COBRA NOTIFICATION REQUEST FORM

## I. General Information

| | |
|---|---|
| Type of Notification Request: ☐ Specific Rights ☐ General Rights *(Complete Section I and II Only)* | |
| Employer Name: | |
| Contact Name: | |
| Telephone: | Email Address: |

## II. Qualifying Beneficiary Information

| | | |
|---|---|---|
| First Name: | Last Name: | SSN: |
| Employee Name (if different than QB): | | SSN: |
| Date of Birth: | Email Address: | |
| Telephone: | Gender: ☐ Male ☐ Female | Is Person Totally Disabled? ☐ Yes ☐ No |
| Mailing Address Line 1: | | |
| Mailing Address Line 2: | | |
| City: | State: | Zip: |

## III. Specific Rights Event Detail

| | |
|---|---|
| Hire Date: | |
| COBRA Event Date: | COBRA Start Date: |

Event Details:

☐ Termination
☐ Termination - Involuntary
☐ Reduction in Hours – Status Change
☐ Reduction in Hours – End of Leave
☐ Reduction in Force (Layoff)
☐ Retirement
☐ Loss of Eligibility
☐ Divorce/Legal Separation
☐ Ineligible Dependent
☐ Medicare
☐ Death

Assistance Eligible Individual (AEI) for ARPA COBRA Subsidy 4/1/21-9/30/21: ☐ Unknown ☐ Eligible ☐ Ineligible

## IV. Current Insurance Coverage

| Plan Type | Carrier<br>Ex. Tufts, HPHC, BCBS | Plan Name<br>Ex. PPO, HMO | Coverage Level<br>Ex. Individual, 2 Person, Family | QB Covered Until |
|---|---|---|---|---|
| Medical Plan | | | | ☐ Event Date<br>☐ End of Month |
| HRA ☐ Yes ☐ No | | | | ☐ Event Date<br>☐ End of Month |
| Dental Plan | | | | ☐ Event Date<br>☐ End of Month |

| | | | | |
|---|---|---|---|---|
| Vision Plan | | | | ☐ Event Date<br>☐ End of Month |
| Flexible Spending Account (FSA) | | Annual Election:<br>$ | Total payroll deductions as of final paycheck:<br>$ | ☐ Event Date<br>☐ End of Month |

## V. Dependent Information

| First Name | Last Name | Date of Birth | SSN | Relationship |
|---|---|---|---|---|
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