Termination of Insurance Coverage to be completed by: ☐ Davevic Benefit Consultants ☐ Employer

COBRA NOTICE OF QUALIFYING EVENT

Employer Name		**Date Insurance Coverage Terminates**	
Employee Name			
Social Security #			
Street Address		**Date of Birth**	
City, State, Zip		**Date of Hire**	
Telephone No.		**Date Benefits Started**	

Coverage Termination:

Event Date	Reason for Termination	If Name and address of Qualified Beneficiary is different From employee, please complete below:	
	Termination of Employment		
	☐ Voluntary	Qualified Beneficiary Name	
	☐ Involuntary	Street Address	
	Divorce/Legal Separation	City, State, Zip	
	Dependent Status	Was the Qualified Beneficiary disabled (under Social Security Act Provisions) at the time of the termination or Reduction in hours?	
	Death of Employee		
	Reduction in Hours	YES ☐ NO ☐	
	Medicare Entitlement	Was employee covered under Medicare prior to the Qualifying event?	
Note: Please enter actual date event occurred in space above		YES ☐ NO ☐	
		If yes, what was effective date of Medicare coverage?	
	Date Notice Mailed	Month:	Year:

Type of Coverage Prior to Qualifying Event:

	Plan Name	Group #	Level of Coverage (Single-Parent/CH-H&W –Family)
1.			
2.			
3.			
4.			

Dependent(s) to be covered. (Only those individuals who lost coverage as a result of the qualifying event.)

	Name	Social Security #	Date of Birth
Spouse			
Child			
Child			
Child			

Please complete the above form for COBRA mailing requirements and transmit via fax number 724.458.4464 or email cobra@davevic.com for processing.