DAVEVIC

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 #		**Tobacco User**	**Yes**		**No**	
Street Address		**Date of Birth**				
City, State, Zip		**Date of Hire**				
Telephone No.		**Date Benefits Started**				

NOTE: ALL FIELDS ARE REQUIRED

Coverage Termination:

Event Date	Reason for Termination	If Name and address of Qualified Beneficiary is different From employee, please complete below:			
	Termination of Employment				
	Reduction in Hours	Qualified Beneficiary Name			
	Divorce/Legal Separation	Street Address			
	Dependent Status	City, State, Zip			
	Death of Employee	Was the Qualified Beneficiary disabled (under Social Security Act Provisions) at the time of the termination or Reduction in hours?			
	Medicare Entitlement				
Note: Please enter actual date event occurred in space above		YES		NO	
		Was employee covered under Medicare prior to the Qualifying event?			
		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	Tobacco (Y/N)	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 group@davevic.com for processing.