GROUP ADMINISTRATORS, LTD.
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TERMINATION / COBRA ACTION REPORT

Company Name: Division No:_____

Company Contact:_____Phone: (_ _ _)_____

Employee Name: (Last)_____(First) _____

Address:_____City:_____State:_____Zip:_____

DOB:_____Phone:_____

Qualifying Event Information

	Type of Event	Date of Event	Date of Loss of Coverage
[ ]	Involuntary Termination of Employment	_____	_____
[ ]	Voluntary Termination of Employment	_____	_____
[ ]	Involuntary Reduction in Hours	_____	_____
[ ]	Voluntary Reduction in Hours	_____	_____
[ ]	Employee Death	_____	_____
[ ]	Divorce or Legal Separation*	_____	_____
[ ]	Loss of Dependent Status*	_____	_____
[ ]	Medicare Eligibility	_____	_____
[ ]	Eligible for USERRA (Military Reserve Call Up)	_____	_____
[ ]	Retirement	_____	_____

If COBRA billing is not to commence on the Date of Loss of Coverage, indicate beginning date: _____

Is this a Secondary Event? Y N (Please Circle) If Yes, date of original event: _____

*For Divorce or Dependents Loss of Status, please complete the information below:

Name of Dependent (s)	Address, if other than indicated above	Date of Birth	Social Security No.

Comments: _____

Plan Information

Coverage Level Codes: **E**-Employee Only, **ES**-Employee and Spouse, **EC**-Employee and Child, **ECN**-Employee and Children, **F**-Employee and Family, **S**-Spouse Only, **C**-Child Only, **SC**-Spouse and Child(ren) Only

Plan of Benefits	Name of Plan	Coverage Level
Medical/Rx		
Dental		
Vision		
Employee Assistance Program		
Other:		
Flexible Spending Account	Year to Date Contribution $_____	