



GROUP ADMINISTRATORS, LTD.

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TERMINATION / COBRA ACTION FORM

Company Name: Division No: _____
Company Contact: _____ Phone: (____) _____
Employee Name: (Last) _____ (First) _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Phone: _____

Qualifying Event Information

<u>Type of Event</u>	<u>Date of Event</u>	<u>Date of Loss of Coverage</u>
[] Termination of Employment	_____	_____
[] Reduction in Hours/Leave of Absence	_____	_____
[] Employee Death	_____	_____
[] Divorce or Legal Separation*	_____	_____
[] Loss of Dependent Status*	_____	_____
[] Medicare Eligibility	_____	_____
[] Eligible for USERRA (Military Reserve Call Up)	_____	_____

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:

<u>Name of Dependent (s)</u>	<u>Address, if other than indicated above</u>	<u>Date of Birth</u>	<u>Social Security No.</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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