PENNSYLVANIA COBRA QUALIFYING EVENT FORM

TO: **Human Resources America, Inc.**
P.O. Box 8 DATE: _____
Houston, PA 15342
Via Fax (724)-514-6648
Via E-Mail linda.rall@hracobra.com , alena.loiselle@hracobra.com **,** or robert.loiselle@hracobra.com

FROM: _____ (Company name) _____ (Contact name)

_____(Company address)_____ (Contact Telephone)

_____ (City, State, Zip Code)_____(E-mail address)

Billing for COBRA notification service sent to(**AGENCY**): _____

Name of Insurance Carrier_____ (Please list additional plan carriers on separate sheet)

Address_____(Street, City, State, Zip Code) Customer Service Telephone _____

Medical & Prescription

Rates

Individual_____Individual + Spouse_____Individual + 1_____

Individual + Child_____Individual + Children_____Family_____

Contract Year beginning date _____ to _____.
Can this be converted to an individual policy after Cobra term? Yes No
Age dependents become ineligible ( ) Full time Student ( )
Date coverage terminates - Last day of employment ( ) End of the month ( )

EMPLOYEE ELIGIBLE FOR COBRA CONTINUATION COVERAGE

Name of Employee: _____SS #_____ Date of Birth_____

Current Address of Employee: _____(Street, City, State, Zip Code)

Name of Spouse_____ Date of Birth_____ SS #_____

Dependent Name: _____ Date of Birth_____ SS #_____

_____ _____Date of Birth_____ SS #_____

_____ Date of Birth_____ SS #_____

_____Date of Birth_____ SS #_____

Qualifying Event Date (last day of paid employement): _____ End of Coverage date: _____

Hire Date_____ Original Coverage Date_____

Plan names or # _____Tier(Single, Emp. & Spouse, etc.)_____

Qualifying Event (please check one):

_____ 1. A reduction of hours resulting in ineligibility for the Plan ***(not eligible for the ARRA subsidy)***
_____ 2. Involuntary Termination of employment *(for reasons other than gross misconduct)*
_____ 3.Voluntary Termination of employment ***(not eligible for the ARRA subsidy)***
_____ 4. The death of employee
_____ 5. Divorce or legal separation from employee
_____ 6. Dependent child ceasing to be a dependent under the "Plan" Child's Name_____SS#_____
_____ 7. Employee's entitlement to Medicare
_____ 8. Failure of employee to return from a leave of absence under the Family and Medical Leave Act of 1993