COBRA Qualifying Event Notification Form

Enter Online at www.MyTPAOnline.com
or return completed form to
cobra@bmsllc.net or Fax (502) 244-1162

BMS LLC
BENEFIT MARKETING SOLUTIONS
P.O. Box 43653 Louisville, KY 40253-0653
PHONE (502) 244-1161 www.bmsllc.net

COMPANY NAME: _____

Employee Information

☐ Male ☐ Female

First	M.I.	Last	Gender

Street Address **Apartment/Unit #**

City **State** **Zip Code**

Social Security #	Birth Date	Date of Hire	Benefit Begin Date	Qualifying Event Date

COBRA Qualifying Event

☐ Termination of covered employee's employment for any reason; *other than gross misconduct* (18 Months)

☐ Reduction in covered employee's hours worked (18 Months)

☐ Covered Employee becomes entitled to Medicare; if event causes loss of coverage under the plan (36 Months)

☐ Divorce or legal separation of the Spouse from the covered employee (36 Months)

☐ Loss of dependent child status under the rules of the plan (36 Months)

☐ Death of a covered employee (36 Months)

Qualified Beneficiaries/Covered Dependents

Name	Social Security #	Birth Date	Relationship	Full-time Student
			☐ Spouse ☐ Child	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No

Employee Enrollment Prior to Qualifying Event

Health Insurance Carrier:

Plan Name: _____

Type of Coverage
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Monthly Premium: $_____

Dental Insurance Carrier:

Plan Name: _____

Type of Coverage
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Monthly Premium: $_____

Vision Insurance Carrier:

Plan Name: _____

Type of Coverage
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Monthly Premium: $_____

Health Reimbursement Arrangement Carrier:

Plan Name: _____

Type of Coverage
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Monthly Premium: $_____

Medical Spending Account (FSA) Carrier:

Plan Name: _____

(Employees enrolled in a Cafeteria Plan Flexible Spending Account (FSA) should be offered the right to pay after-tax premiums and continue in the plan if their account has a positive balance at the time of their termination.)

Monthly Contribution: $_____

Other COBRA Eligible Group Plan Carrier:

Plan Name: _____

Type of Coverage
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

Monthly Premium: $_____

I certify the beneficiary noted above has experienced a qualifying event and is eligible for COBRA. I have notified the Plan Administrator (BMS LLC) within the maximum 30-day period for the Administrator to proceed with notifying the qualified beneficiary within the required DOL timeframe.

Employer's Signature: _____ Date: _____

Accepted and Completed by BMS LLC Representative: _____ *Date:* _____