COBRA QUALIFYING EVENT NOTIFICATION FORM

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

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

☐ **Voluntary** ☐ **Involuntary** 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:* ______________