COBRA Participant Takeover Form

COBRA Participant Information:

First Name	***Last Name***	***SSN***	***Original Coverage Effective Date:***
			_____/_____/_____

Mailing Address	***Apt/Suite #***		***City***	***State***	***Zip***

Date of Birth	***Gender***	***Daytime Phone #***	***Employer:***
_____/_____/_____	☐ Male ☐ Female	(_____)_____-_____	

Names of Dependents Currently on COBRA:

Name	Date of Birth	SSN	Relationship	Qualifying Event

Employee's Name (If the COBRA participant listed above is a dependent):

Name: _____ Social Security Number: _____ Date of Birth: _____

COBRA Qualifying Event Information:

Event Date: _____ Date Election Notice Mailed: _____

Event Reason: ☐ Involuntary Termination ☐ Reduction of Hours ☐ Voluntary Termination ☐ Employer Bankruptcy ☐ Child Ceasing to be a Dependent ☐ Entitlement to Medicare ☐ Divorce/Legal Separation ☐ Death of Covered Employee

COBRA Coverage Paid Through Date: _____

Group Health Plan Coverage and Benefit Tier: Enter premium amount for tier in which participant is currently enrolled for all applicable plans.

	Medical	HRA	Dental	Other
Employee Only	$	$	$	$
EE + Spouse	$	$	$	$
EE + Child	$	$	$	$
EE + Family	$	$	$	$

Submitted by: _____ Date: _____