

**COBRA
Notification Form
(Loss of Coverage)**



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EMPLOYEE INFORMATION

Employer _____ Date of Birth _____

Employee Last Name _____ First Name _____ Middle Initial _____

Last Known Employee Mailing Address (Street) _____ (Apt. #) _____ (City) _____ (State) _____ (ZIP) _____

Sex: M F

_____ Date of Hire _____ Phone Number _____

TYPE OF QUALIFYING EVENT

Date of Qualifying Event: _____ Date Original Insurance Began: _____ Date Active Insurance Ends: _____

Termination Involuntary Termination Reduction in Hours Medicare Entitlement Ineligible Dependent
 Retirement Divorce/Legal Separation Leave of Absence Military Service Death of Employee

INSURANCE COVERAGE

Name of Insurer	Premium Per Month	Employee Only	Employee + Spouse	Employee + Family	Employee + Child(ren)
Medical:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee Assistance Program (EAP):					
Flexible Spending Account (FSA) per month:*					
Health Reimbursement Arrangement (HRA)					

*Complete FSA section only if balance is not deducted from final paycheck.

Covered Dependents (Name)	Sex (M/F)	Date of Birth	Address If Different from Employee
Spouse:			
Child:			
Child:			
Child:			
Child:			

Period of Insurance Coverage for Dependents <i>if different from that of the employee</i>	Start Date	End Date

Will Employer pay COBRA premium as part of severance package? Yes No

Payment End Date: _____

Name of Person Preparing Form: _____ Date: _____

Phone Number: _____