

**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 _____ Social Security 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 | Social Security number | 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: _____

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