COBRA CONTINUATION SERVICES

(To transfer current COBRA Participant to NABCO)

North American
Benefits Company

Suite 310
20 Valley Stream Parkway
Malvern, Pennsylvania 19355

Email: cobra@nabenefits.com
Phone: 610-995-0169

Employer Name: ______________________ **Date:** __________

Following is currently on COBRA Continuation: ☐ Employee ☐ Dependent

1. COBRA Participant Information:

1a. ____________ COBRA Continuant Name (Last, First, MI) ____________ Social Security Number ____________ Date of Birth ☐ Male ☐ Female

1b. ____________ Billing Address ____________ City ____ ST ____ Zip ____________ Phone

1c. Date of Hire: __________ Marital Status (Check one box only): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2. Qualifying Event:

2a. QE Date: __________ Last day of COBRA Coverage: __________

2b. First premium due-date for which NABCO is to begin COBRA continuation billing: __________

2c. Qualifying Event that caused loss of coverage (check one):

1. Continuation of coverage for 18 Months
   - ☐ Employee's termination of employment (includes voluntary and involuntary (except when due to gross misconduct), retirement, layoff, or leave of absence)
   - ☐ Employee's reduction in work hours (includes work stoppage or strike)
2. Continuation of coverage for 36 Months
   - ☐ Death of covered employee/retiree ☐ Divorce/legal separation ☐ Ineligibility of dep. Child
   - ☐ Covered employee/retiree becomes entitled to Medicare; dependent may elect continuance of Identical coverage
   - ☐ Retiree, spouse or child of retiree loses coverage within 1 year before or after commencement of proceeding under Title II (bankruptcy)

3. Current Plan Coverage:

3a. Check the current plan code coverage. NABCO administers only plan code coverage options that are permitted by your plan or carrier.

☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

3b. Has the continuant been approved for an additional 11-month disability extension? ☐ Yes ☐ No

3c. At the time of the termination or reduction in hours, was the employee eligible to receive Social Security income? ☐ Yes ☐ No

3d.

	☐ Health	☐ Dental	☐ Vision
Carrier Name:			
Plan Description:			
Coverage Level:			
Effective Date:			
Last Date of Coverage:			

Medicare Coverage: ☐ Yes ☐ No If yes, Effective Date:

Employer Name: ______________________ **Date:** ____________

4. Dependents:

4a. If the COBRA Participant has dependent coverage, please complete the following for each covered dependent:

1. ______________________ ______________ ______________ ☐ Male ☐ Female

Dependent Name (Last, First, MI) | Social Security Number | Date of Birth

____
Relationship to Employee

Qualified Beneficiary Status as of QE: ☐ Yes ☐ No

Same Billing Address as 1a: ☐ Yes ☐ No (If NO provide complete address) →

2. ______________________ ______________ ______________ ☐ Male ☐ Female

Dependent Name (Last, First, MI) | Social Security Number | Date of Birth

____
Relationship to Employee

Qualified Beneficiary Status as of QE: ☐ Yes ☐ No

Same Billing Address as 1a: ☐ Yes ☐ No (If NO provide complete address) →

3. ______________________ ______________ ______________ ☐ Male ☐ Female

Dependent Name (Last, First, MI) | Social Security Number | Date of Birth

____
Relationship to Employee

Qualified Beneficiary Status as of QE: ☐ Yes ☐ No

Same Billing Address as 1a: ☐ Yes ☐ No (If NO provide complete address) →

4. ______________________ ______________ ______________ ☐ Male ☐ Female

Dependent Name (Last, First, MI) | Social Security Number | Date of Birth

____
Relationship to Employee

Qualified Beneficiary Status as of QE: ☐ Yes ☐ No

Same Billing Address as 1a: ☐ Yes ☐ No (If NO provide complete address) →

Comments:

5. Completed By:

Name: ______________________ Date: ____________ Phone: ______________________