COBRA NOTICE OF QUALIFYING EVENT

(Return completed form to NABCO no later than 30 days following QE)

North American
Benefits Company

Suite 310
20 Valley Stream Parkway
Malvern, Pennsylvania 19355

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

Employer Name: ______________________ **Hire Date:** ________ **Date of QE:** ________

1. Employee Information:

Employee Name (First, Last, MI) | Social Security Number | Date of Birth | ☐ Male | ☐ Female

Billing Address | City | ST | Zip | Phone

2. Family Member(s) Losing Coverage: (complete separate forms for family members at different address)

Spouse Name (First, Last, MI) | Social Security Number | Date of Birth | ☐ Male | ☐ Female

Address | City | ST | Zip | Phone

Other Covered Dependent Names (at same address)	Relationship	Social Security Number	Date of Birth

3. Current Benefits:

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

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

4. Qualifying Event:

☐ Divorce ☐ Child losing Dependent Status ☐ Entitlement to Medicare

☐ Death of Employee ☐ Reduction of Hours ☐ Termination of Employment:
- ☐ Voluntary ☐ Involuntary
- ☐ Severance ☐ USERRA Qualified

5. Completed By:

Name: ______________________ Date: ________ Phone: ______________