CBA Benefit Services
73 East Wilson Bridge Road, Suite B-6 - Worthington, Ohio 43085
(614) 880-0068 - Toll free (866) 880-0068 - Fax (614) 880-0092

To: COBRA Coordinator
Fax: 1-614-880-0092
Date: _____

COBRA REPORTING FORM

Employer Name

The following person has incurred a Qualifying Event. The employer was notified on _____/_____/_____.

Name	Social Security Number
Street Address	Birth Date
City, State, Zip	Home Telephone ( )
** Employee's Name (if different)	Employee's Social Security #

This person was covered under the following benefits:

❒ MEDICAL/RX (COVERAGE END DATE_____)
- ❒ Employee with Single Coverage
- ❒ Employee with Dependent Coverage
- ❒ Dependent of Employee

❒ VISION (COVERAGE END DATE_____)
- ❒ Employee with Single Coverage
- ❒ Employee with Dependent Coverage
- ❒ Dependent of Employee

❒ DENTAL (COVERAGE END DATE_____)
- ❒ Employee with Single Coverage
- ❒ Employee with Dependent Coverage
- ❒ Dependent of Employee

❒ FLEX BENEFIT PLAN (Per Month)
$_____ Flexible Spending
$_____ Dependent Care

❒ EAP

The event that caused termination of benefits was:

EVENT	DATE OF EVENT
Employment terminated	
Reduction in hours	
Employee retired	
Death of an employee	
Dependent Child loses eligibility ❒ Graduation ❒ Limiting Age	
Medicare entitlement	
Family Medical Leave Act expiration	
Divorce final	
Other – Reason	

Employer Representative _____ Date _____

Recommended procedure: fax or mail CBA Benefit Services within 30 days of QE and file copy in employee's personnel file.

CBA USE ONLY:	
❒ TERMINATE APPLICABLE COVERAGES	❒ LOAD INFORMATION IN COBRA SYSTEM
❒ADVISE OTHER CARRIERS OF TERMINATION IF APPLICABLE	❒ MAIL NOTIFICATION LETTER TO PQB