COBRA QUALIFYING EVENT FORM

(To be completed by Human Resources personnel and faxed to Boulder Administration at 406/225-3521)

EMPLOYEE INFORMATION

EMPLOYEE NAME: ____________________

EMPLOYEE ADDRESS: ____________________

____

EMPLOYER GROUP NAME: ____________________

____

EMPLOYEE HOME PHONE NUMBER: ( ) ____________________

EMPLOYEE SOCIAL SECURITY # ____________________

DATE OF QUALIFYING EVENT: ____________________

EMPLOYEE GENDER ❑ Male ❑ Female

QUALIFYING EVENT

Employee

_____ Layoff
_____ Reduction in Hours
_____ Non-COBRA
_____ Termination
_____ Retirement

Spouse/Children (Circle one or both)

_____ Divorce or Legal Separation
_____ Death of Employee
_____ Non-COBRA termination
_____ Ineligible Child
_____ Other

PRESENT COVERAGE

PLAN NAME	ENROLLMENT STATUS				CURRENT PREMIUM
	❑ EE Only	❑ EE/Spouse	❑ EE/Child	❑ Family	$

PERSONS CURRENTLY ENROLLED

FIRST AND LAST NAME	SEX	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION TO EMPLOYEE SP=Spouse CH=Child	DATE MEDICAL COVERAGE BEGAN	DATE COVERAGE ENDED
	M F					
	M F					
	M F					
	M F					
	M F					
	M F					
	M F					

BILLING ADDRESS IF DIFFERENT FROM EMPLOYEE ADDRESS:

____________________ ( ) ____________________
Name Phone

____
Street Address City State Zip Code

QUESTIONS? CALL
BOULDER ADMINISTRATION
COBRA Administrator
For New West Health Services and New West Health Plan

Toll Free: 877-406-3699
Phone: 406 225-3699

Faxed By: ____________________

Address: ____________________

____

Date: ____________________

Phone: ____________________

Please fax to Boulder Administration 406-225-3521