Preferred Health Plan of the Carolinas

NOTICE TO PLAN ADMINISTRATOR OF TERMINATION AND COBRA QUALIFYING EVENT

GROUP NAME ______

DATE___________

COVERED EMPLOYEE NAME & DOB _____________________________

COVERED DEPENDENTS NAMES & DOBS_________________________

____

____

COVERED EMPLOYEE SS# ______________________________________

COVERED EMPLOYEE ADDRESS ________________________________

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MEDICAL COVERAGE (circle one)EE , EE/SPOUSE, EE/CHILD, FAMILY, NONE
DENTAL COVERAGE (circle one)EE , EE/SPOUSE, EE/CHILD, FAMILY, NONE

DATE OF QUALIFYING EVENT ________________________________

PLEASE CHECK APPLICABLE QUALIFYING EVENT

____DEATH
____VOLUNTARY TERMINATION OF EMPLOYEE
____INVOLUNTARY TERMINATION OF EMPLOYEE
____REDUCTION IN HOURS OF EMPLOYMENT
____ELIGIBILITY FOR MEDICARE BENEFITS
____DIVORCE/LEGAL SEPARATION OF COVERED EMPLOYEE
____CESSATION OF DEPENDENT-CHILD STATUS UNDER THE PLAN

NOTICE PREPARED BY____________________________DATE________