

COBRA NOTICE ACTION FORM



PO Box 2639 • Lilburn, GA 30048 • 770-451-7550

| | | |
|------------------------------------------------|------------------------------------------------------|--------------|
| Employer Name | | Group Number |
| Employee Name | | |
| Qualified Beneficiary (if other than Employee) | | |
| Address (Street, City, State, Zip Code) | | |
| Termination Date (Month/Date/Year) | Effective Date Coverage Terminates (Month/Date/Year) | |

IF COBRA IS REQUIRED, COMPLETE THE FOLLOWING:

Qualifying Event: (Check one)

- Termination/Retirement other than gross misconduct (18 month COBRA period, 29 month Social Security Disability)
- Reduction in hours, includes Medical or Personal Leave of Absence, Suspension or Activated Military Reserve (18 month COBRA period, 29 month Social Security Disability)
- Death of a covered Employee (36 month COBRA period)
- Divorce or legal separation (36 month COBRA period)
- A dependent ceases to be a dependent as defined by the Employer's Group Plan (36 month COBRA period)
- Covered employee is entitled to Medicare (36 month COBRA period)
- Employer files for bankruptcy (Applies to retiree coverage only)

IF COBRA IS NOT REQUIRED, COMPLETE THE FOLLOWING:

(Check one)

- Voluntarily dropping all coverage
- Voluntarily dropping all spouse and/or dependent coverage
- Other group insurance without pre-existing conditions
- Retiring and entitled to Medicare with no spouse and/or dependents on current coverage, or spouse and/or
- Other (explain)

| | |
|--------------------|------|
| Employee Signature | Date |
|--------------------|------|

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| For TPA of Georgia's Use Only | Date Received | Date Given to COBRA Dept |
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