Qualifying Event Notification Form

Please return form to: **Precision Administrators, Inc.**
3240 W Britton Rd, Suite 202
Oklahoma City, OK 73120

Fax:(405)507-0700
cobra@paibenefits.com
Questions? Call 1-800-615-2797

Employer Name_____

The following individual has had a qualifying event:
☐ Employee ☐ Dependent

Name of Qualified Beneficiary:

Social Security Number:
☐☐☐-☐☐-☐☐☐☐

Date of birth: | Gender:

Address:

If the Qualified Beneficiary listed above is not the employee, enter the following:
Employee Name _____
Employee SSN _____ - _____ - _____
Dependent's Relationship to Employee _____

Qualifying Event Date:

Is this a secondary event for a dependent that is currently on COBRA? __ Yes __ No

Covered dependent information:

Spouse Name: _____
Social Security Number: _____ - _____ - _____
Date of Birth: _____ Gender: _____
Address (if different from participant):
_____

Dependent Name: _____
Social Security Number: _____ - _____ - _____
Date of Birth: _____ Gender: _____
Address (if different from participant):
_____

Dependent Name: _____
Social Security Number: _____ - _____ - _____
Date of Birth: _____ Gender: _____
Address (if different from participant):
_____

Dependent Name: _____
Social Security Number: _____ - _____ - _____
Date of Birth: _____ Gender: _____
Address (if different from participant):
_____

COBRA Qualifying Event that caused loss of coverage (check one):

Continuation of coverage for 18 months:

Employee's retirement
Employee's reduction in hours
Employee's resignation
Employee's layoff
Employee's involuntary termination
Employee's begins leave of absence

Continuation of coverage for 36 months:

Divorce / legal separation
Death of covered employee / retiree
Ineligibility of dependent child
Covered employee/retiree becomes entitled to Medicare; dependents may elect continuation of coverage

Coverages in effect on the qualifying event date:
If applicable, list plan option (i.e. HMO vs. PPO) and indicate coverage level according to codes listed below

	Option	Code
Health		
Dental		
Vision		
HRA		

Coverage codes:
1 – individual
2 – individual + spouse
3 – family
4 – individual + child(ren)

If qualified beneficiary is the employee, does he/she have a health care FSA? Yes No
Monthly Contribution_____