VIGILANT
benefits for employers

COBRA QUALIFYING EVENT FORM

Date: ____________

Employer Name: ______________________ Division: ______________________

Prepared by: ______________________ Phone: ______________________

EMPLOYEE'S PERSONAL INFORMATION

Note: If the employee is *not* the individual losing coverage, only the SSN and Name fields must be completed.

SSN	First Name	Last Name	MI	Gender ❑ M ❑ F

Street Address	City	State	Zip Code

Original coverage effective date	DOB	N/A ❑

List all enrolled dependents. If the address is the same as the employee's please note "same".

SSN	First Name	Last Name	MI	Gender ❑ M ❑ F

Street Address	City	State	Zip Code

Original coverage effective date	DOB	Dependent type ❑ Spouse/DP ❑ Dependent child

SSN	First Name	Last Name	MI	Gender ❑ M ❑ F

Street Address	City	State	Zip Code

Original coverage effective date	DOB	Dependent type ❑ Spouse/DP ❑ Dependent child

SSN	First Name	Last Name	MI	Gender ❑ M ❑ F

Street Address	City	State	Zip Code

Original coverage effective date	DOB	Dependent type ❑ Spouse/DP ❑ Dependent child

QUALIFYING EVENT (QE) INFORMATION

Qualifying Event Date ______________

- ❑ Reduction in hours
- ❑ Involuntary Termination
- ❑ Voluntary Termination
- ❑ Death of Employee
- ❑ Medicare Entitlement
- ❑ Divorce/Legal Separation
- ❑ Ineligible Dependent

BENEFIT PLAN INFORMATION

Medical Plan Name	Dental Plan Name	Vision Plan Name
❑ Single ❑& Sp ❑& Child(ren) ❑& Fam	❑ Single ❑& Sp ❑& Child(ren) ❑& Fam	❑ Single ❑& Sp ❑&Child(ren) ❑& Fam

FSA Coverage ❑ Yes ❑ No If yes, monthly premium $ ________ HRA Coverage ❑ Yes ❑ No If yes, monthly premium: $ ________

Severance Agreement ❑ Yes ❑ No Begin Date ____________ End Date ____________

Employer premium payment during severance: Medical $ ________ Dental $ ________ Vision $ ________

Vigilant Use Only: Date Processed: ____________ Processed By: __________ Notes: ______________________

Instructions for completing this COBRA Qualifying Event form:
Complete this form for the individual(s) losing coverage (Qualified Beneficiaries or "QBs"). If the QB is an individual other than the employee, (for example if the qualifying event is a divorce, the QB would be the spouse), only the employee's SSN, and first and last name need to be entered on this form and the N/A box marked. All other applicable fields on the form should be completed.

Be sure to notify Vigilant Services, Inc. as soon as an individual experiences a qualifying event, but in any case no later than 30 days of the date of the qualifying event.

Original Coverage Effective Date: This date is used for HIPAA purposes (for example, to determine whether there has been a recent lapse in coverage). The date entered should reflect the most recent enrollment date for the individual.

EXAMPLE 1: if the employee's coverage was originally effective on 2/1/2009, terminated on 5/31/2009; reinstated on 2/1/2010 and then terminated again on 4/30/2010, the original coverage effective date should indicate 2/1/2010.

EXAMPLE 2: If the individual's coverage was effective on 7/1/2004 and has remained employed and covered under your plan since that time, the original coverage effective date would be 7/1/2004.

Qualifying Event Date: This is the *actual* date of termination, reduction of hours, death, etc. For example, if the employee is terminated on October 13th, this date should be entered into the Qualifying Event Date box, and *not* the last day of the month.

Personal Information: Please provide as much detail as possible, including SSN and date of birth, etc.

Benefit Plan Information: List the plan and insurance company name, and check the appropriate coverage tier (employee only, employee and spouse, etc.).

Dependent Information: List all dependents covered under the plan on the day before the qualifying event. Be sure to include the appropriate address for any dependents not currently living at the home address of the employee.

***Health FSA and HRA Coverage:** Please indicate whether the individual was enrolled in either an HRA or FSA on the day before the qualifying event and whether they are eligible to continue that coverage under COBRA. Note the applicable monthly premium amount, *only if VSI manages COBRA for these services.

Incomplete forms may be delayed or returned to the employer for additional information. Should you have any questions regarding COBRA or need assistance with completing the form, please contact us at 503.620.1710 or 800.733.8621.