GROUP INSURANCE SERVICE CENTER, INC.
COBRA NOTIFICATION FORM

NAME OF EMPLOYER:_____

Name of Covered Employee:_____

Address:_____

Social Security Number:_____

Date of Hire:_____ Date of Birth:_____

Employee currently covered by Medicare: ❑ Yes ❑ No

Name of covered spouse:_____

Spouse's Address:_____

Social Security Number:_____ Date of Birth:_____

Name of Covered Child(ren):_____ SS#_____

Children's Address:_____

Type of Qualifying Event (Check all items that apply):

- ❑ Death of Covered Employee
- ❑ Termination of Covered Employee (other than by reason of gross misconduct)
- ❑ Reduction of hours of Covered Employee
- ❑ Divorce or Legal Separation of Covered Employee
- ❑ Covered Employee's entitlement to Medicare Benefits
- ❑ Disabled Individual who has sent notice of his/her Social Security Disability Determination
- ❑ Dependent child ceasing to be a Dependent under the Plan's terms

Last day of coverage (termination date):_____ This date is defined in your Plan Document under termination on your Summary Plan Information page. Please refer to your Plan Document before filling in this date.

Currently covered and thereby entitled to:

	Single	Two-Person	Family
❑ Health Plan	❑	❑	❑
❑ HMO_____	❑	❑	❑
❑ Dental	❑	❑	❑
❑ Vision	❑	❑	❑

_____ _____

Administrator's Signature Date

8/98