Qualifying Event for COBRA Continuation / HIPAA Certificate

Date: ______/______/______

Employer Name: ______________________

Group Number: _________________

Qualified Beneficiary Information

Name: ____

Social Security #: ____

Address: ____

City, State, Zip: ____

Marital Status: ☐ Single ☐ Married

Date of Hire: ______/______/______

Date Coverage Began: ______/______/______

Date Coverage Ended: ______/______/______

On ________________________ (date), the above qualified beneficiary incurred the following "qualifying event" which caused the individual to lose group health coverage for purposes of COBRA continuation:

- ☐ Termination of Employment
- ☐ Reduction of hours due to ______________________________________
- ☐ Death of Employee
- ☐ Employee's Medicare Entitlement
- ☐ Employer's Bankruptcy
- ☐ Divorce or Legal Separation from Employee
- ☐ Dependent Child ceasing to be a dependent

Please send the above person (and his or her spouse and dependent child(ren), if any) the appropriate election notices and forms for COBRA Continuation of Coverage and a HIPAA Certificate of Coverage within 14 days of the receipt of this notice.

Signature: ____ Title: ___________________

SUBMIT COMPLETED FORM TO:

CORE Benefits, Inc.
P.O. Box 80465
Fort Wayne, IN 46898-0465
Ph: 260.492.7451 866.744.8482 Fax: 260.492.7292