



Quality, Compliance & Service

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