Ceridian COBRA Continuation Services

COBRA QUALIFYING EVENT

CS-613/7/04

PLEASE CHECK ONE BOX ⇨ ☐ ORIGINAL NOTICE If FAXED, do not mail copy.
☐ REVISION . . . to a form that was previously sent.

1a) From (Company)

1b) Division or Region Code ☐☐☐

1c) Company ID or Unit Code ☐☐☐

(If applicable, refer to the Client Rate Report for the one character to two characters required [alpha and/or numeric] to complete 1b and 1c above.)

2) Ceridian COBRA Services Account Number

3) Please be advised that the following has had a Qualifying Event. (check one)
☐ (E)mployee ☐ (D)ependent

4) Social Security Number of Qualified Beneficiary
☐☐☐-☐☐-☐☐☐☐

5a) Qualified Beneficiary's Name (last, first, mi)

5b) Street (include apartment number)

5c) City | 5d) State | 5e) Zip Code

6) Home Phone # of Qualified Beneficiary (include Area Code)
☐☐☐-☐☐☐-☐☐☐☐

7) Employee # (if applicable)

8) Date of Birth of Qualified Beneficiary
☐☐☐☐☐☐☐☐
M M D D Y Y Y Y

9) Gender (check one)
☐ (M)ale
☐ (F)emale

10) If the Qualified Beneficiary listed in box #5a is not the employee, enter the following:
Employee Name (last, first, mi)________________
Employee SSN ☐☐☐-☐☐-☐☐☐☐
Dependent's Relationship to Employee________________

11) Qualifying Event Date
☐☐☐☐☐☐☐☐
M M D D Y Y Y Y

12) Last day of pre-COBRA Coverage (cannot be prior to Qualifying Event Date)
☐☐☐☐☐☐☐☐
M M D D Y Y Y Y

13) Is this a second Qualifying Event for a dependent who is currently on COBRA? ☐ (N)o ☐ (Y)es

14) If employee, does he/she have a health care FSA?
☐ (N)o ☐ (Y)es (If yes, MONTHLY contribution $________________)

15) Refer to your Client Rate Report and enter the current Carrier Option, Option Code and Plan Code for each coverage in effect on the Qualifying Event Date:

	Carrier Code	Option Code	Plan Code*
Med or HMO			
Dental			
Vision			
Hearing			
Prescription			
Other			

*Select from the following current Plan Code Coverages. Ceridian administers only Plan Code coverage options that are permitted by your plan or carrier:

1 = Individual	3 = Family	14 = Individual+Child
2 = Individual + 1	9 = Individual + Spouse	15 = Individual + Children

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

Continuation of coverage for 18 months:

- ☐ Employee's retirement (Code 8)
- ☐ Employee's reduction in hours (Code 2)
- ☐ Employee's resignation (Code 1)
- ☐ Employee's layoff (Code 0)
- ☐ Employee's involuntary termination (Code C)
- ☐ Employee's begins leave of absence (Code 9)

Continuation of coverage for 36 months:

- ☐ Divorce/legal separation (Code 4)
- ☐ Death of covered employee /retiree (Code 3)
- ☐ Ineligibility of dependent child (Code 6)
- ☐ Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings by sponsoring employer under title 11 (bankruptcy) United States Code (Code 7)
- ☐ Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of coverage (Code 5)

17) Spouse/Dependent Information. Each name should include last, first and middle initial.

Name of Spouse________________
Social Security Number ☐☐☐-☐☐-☐☐☐☐
Date of Birth ☐☐☐☐☐☐☐☐
M M D D Y Y Y Y
Gender ☐ Male ☐ Female
Address (if different from participant) ________________

Name of Dependent________________
Social Security Number ☐☐☐-☐☐-☐☐☐☐
Date of Birth ☐☐☐☐☐☐☐☐
M M D D Y Y Y Y
Gender ☐ Male ☐ Female
Address (if different from participant) ________________

Name of Dependent________________
Social Security Number ☐☐☐-☐☐-☐☐☐☐
Date of Birth ☐☐☐☐☐☐☐☐
M M D D Y Y Y Y
Gender ☐ Male ☐ Female
Address (if different from participant) ________________

Name of Dependent________________
Social Security Number ☐☐☐-☐☐-☐☐☐☐
Date of Birth ☐☐☐☐☐☐☐☐
M M D D Y Y Y Y
Gender ☐ Male ☐ Female
Address (if different from participant) ________________

Please see Addendum if additional names need to be listed in this section

Prepared By

Name: (PRINT)________________
Date: ☐☐☐☐☐☐☐☐
M M D D Y Y Y Y
Telephone # ☐☐☐-☐☐☐-☐☐☐☐
Fax # ☐☐☐-☐☐☐-☐☐☐☐