Interactive Medical Systems

Creating Healthier Benefits sm

COBRA Information Needed Form

Company Name: _____

Client ID # _____

Qualified Beneficiary – Social Security Number: _____

Last Name: _____

First Name: _____ Initial _____

Address Line One: _____ Line Two: _____

City: _____ State _____ Zip _____

Date of Birth _____ Phone Number _____

Date of Qualifying Event: _____ Last Day of Active Coverage: _____

COBRA Effective Date: _____

Takeover from other Administrator: Yes – No If yes, Paid Through Date: _____

Is Employee S.S. Disabled: Yes – No If yes, attach S.S. letter

Qualifying Event Type:

Continuation of Coverage for 18 months

_____ Involuntary Term – (104)
_____ Reduction in Hours – Layoff (105)
_____ Retirement (106)
_____ Voluntary Term– Resignation (108)
_____ Termination of Employment (109)

Continuation of Coverage for 36 months

_____ Death of Employee (100)
_____ Divorce (101)
_____ Loss of Dependent Status (102)
_____ Employee Enrolled in Medicare (103)
_____ Legal Separation (107)

Is the Qualified Beneficiary an Employee, Spouse or Dependent: _____

Type of Coverage (Indicate all that apply)

Plan Name (ex. Dental High Plan)	Tier of coverage (ex. Emp/Spouse)	
Plan Name (ex. Dental High Plan)	Tier of coverage (ex. Emp/Spouse)	
Plan Name (ex. Dental High Plan)	Tier of coverage (ex. Emp/Spouse)	
Plan Name (ex. Dental High Plan)	Tier of coverage (ex. Emp/Spouse)	
Medical Spending Acct (FSA)	Annual Amount	Per Pay Amount

Contact Person's Name: _____ Phone No.: _____

Signature: _____ Date: _____

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