

National Benefit Administrators, Inc
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GROUP NAME_____

**NOTICE TO PLAN ADMINISTRATOR
OF COBRA QUALIFYING EVENT**

Date:_____

Covered Employee Name: _____

Covered Dependent(s) Name(s):_____

Covered Employee SSN#:_____

Covered Employee Address:_____

On _____, the following event (checked below) occurred with regard to the covered employee named above:

- _____ Death
- _____ Termination of employment
- _____ Reduction in hours of employment
- _____ Eligibility for Medicare benefits
- _____ Divorce of covered employee
- _____ Legal separation of the covered employee
- _____ Cessation of dependent-child status under the plan

This notice must be provided to the Plan Administrator within fourteen (14) days after the event has occurred or when the covered employee notifies the Personnel Office.

Notice prepared by:_____

