NATIONAL PLAN ADMINISTRATORS, INC.
COBRA NOTIFICATION OF QUALIFYING EVENT

NAME OF DISTRICT/COMPANY: _____

(Employee's Name)
PRIMARY QUALIFIED BENEFICIARY (PQB): _____ ❑ Male ❑ Female

ADDRESS: _____ **SS#**: _____

CITY/STATE/ZIP: _____ **HOME PHONE**: _____

DATE of BIRTH: _____ **DATE of HIRE**: _____

LAST DATE of COVERAGE: _____ **COBRA START DATE**: _____

DATE of QUALIFYING EVENT: _____

QUALIFYING EVENT

❑ Termination ❑ Retirement/ Medicare ❑ Reduced Hours
❑ Death ❑ Divorce/ Legal Separation ❑ Loss of Dependent Child Status

PRE-QUALIFYING EVENT COVERAGES

		✓ To indicate Level of Coverage			
BENEFIT PLAN	**DATE** COVERAGE BEGAN	PQB ONLY	PQB & SPOUSE	PQB & CHILD(REN)	PQB & FAMILY
MEDICAL					
DENTAL					
VISION					
MEDICAL FSA (Benefit will terminate at end of current Plan Year.)		Annual Amount:		Contributions to Date:	

QUALIFYING DEPENDENTS

Name: _____ Relationship: _____ DOB: _____ SS#: _____

Name: _____ Relationship: _____ DOB: _____ SS#: _____

Name: _____ Relationship: _____ DOB: _____ SS#: _____

Name: _____ Relationship: _____ DOB: _____ SS#: _____

PLEASE MAIL OR FAX FORM TO:

National Plan Administrators, Inc. ■ P. O. Box 161630 ■ Austin, TX 78716
Phone: (800) 880-2776 ■ Fax: (800) 982-8140 ■ www.natlplan.com