CBIA Service Corp. — COBRA/State Continuation Services

Qualifying Event Form

APPENDIX B

INSTRUCTIONS: ***Please print clearly***

- Fill out just one form per family unit (Qualified Beneficiary and Dependents)
- Please do not use this form to report existing COBRA/State continuants (use the Continuant Takeover Form).
- Please see back side of this form for further instructions.

COMPLETE THIS FORM AND RETURN IT TO:

CBIA Service Corp. — COBRA/State Continuation Services
350 Church Street
Hartford, CT 06103-1126
Fax: 860-278-0883

NOTE: Even if the Qualified Beneficiary tells you that he or she does not want continuation coverage, send a completed Qualifying Event Notification Form to CBIA Service Corp. within 14 days of the Qualifying Event.

1) From: (Company)

2) CBIA Case Number

3) Please be advised that the following has had a Qualifying Event. *(Check one box only)* ❒ (E)mployee ❒ (D)ependent

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

5a) Name of Qualified Beneficiary (last, first, mi) *(Please print)*

5b) Street Address **5c)** City **5d)** State **5e)** ZIP Code

6) Home Phone #
__ __ __ - __ __ __ - __ __ __ __

7) Date of Birth of Qualified Beneficiary
__ __ __ __ __ __ __ __
M M D D Y Y Y Y

8) Gender ❒ Male ❒ Female

9) Marital Status (check one box only.)
❒ Single ❒ Married ❒ Widowed ❒ Divorced

10) If the Qualified Beneficiary listed in box #5 is not the employee, please complete the following; *(Please print)*
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/State Continuation 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/State Continuation? ❒ Yes ❒ No

14) Qualifying Event that caused loss of coverage (check one)

Continuation of coverage for 18 months:

- ❒ Employee's involuntary termination
- ❒ Employee's resignation
- ❒ Employee's retirement
- ❒ Employee's reduction of hours
- ❒ Employee's layoff
- ❒ Employee begins leave of absence

Continued in next column

Continuation of coverage for 36 months:

- ❒ Death of covered employee/retiree
- ❒ Divorce/legal separation
- ❒ Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage
- ❒ Ineligibility of dependent child
- ❒ Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy) United States Code

15) If the Qualifying Event was for an employee and his/her spouse is covered, enter:
Spouse's full name: _____

Spouse's date of birth: __ __ __ __ __ __ __ __
M M D D Y Y Y Y

16) If the covered dependent(s) reside at a different address from the Qualified Beneficiary, please provide name and address:
(Attach a separate sheet if additional names need to be listed)

Name: _____

Street: _____

City: _____

State: _____ ZIP Code: _____

Form completed by:

Name (print) _____

Date _____

Phone _____ Fax _____

QUALIFYING EVENT FORM
CBIA SERVICE CORP. — COBRA/STATE C SERVICES

Instructions for completing Qualifying Event Form (on reverse side)

(use one form per family unit)

One form should be completed for each family unit and sent to:
CBIA Service Corp. — COBRA/State Continuation Services, 350 Church Street, Hartford, CT 06103-1126

SECTION 1:
Enter your company name.

SECTION 2:
Enter your CBIA Case number.

SECTION 3:
Check appropriate box to indicate whether the Qualified Beneficiary is an employee or dependent. (Check one box only.)

SECTION 4:
Enter the Qualified Beneficiary's complete nine-digit Social Security number.

SECTION 5:
Enter the Qualified Beneficiary's complete name (last, first, middle initial) and complete mailing address (street, city, state and ZIP Code.)

SECTION 6:
Enter the Qualified Beneficiary's home phone number, including area code, if available.

SECTION 7:
Enter the Qualified Beneficiary's date of birth. (month, day, year)

SECTION 8:
Check appropriate box to indicate the Qualified Beneficiary's gender (Male or Female)

SECTION 9:
Check appropriate box to indicate marital status of Qualified Beneficiary.

SECTION 10:
If the Qualified Beneficiary is a dependent of an employee or former employee, enter employee's complete name (last, first, middle initial), employee's nine-digit Social Security Number and Qualified Beneficiary's relationship to employee.

SECTION 11:
Enter the month, day and year of the Qualifying Event.

SECTION 12:
Enter the LAST DAY (month, day, year) of the Qualified Beneficiary's pre-COBRA/State Continuation Coverage.

SECTION 13:
Enter only if a second qualifying event occurs for a dependent already on COBRA/State Continuation.

SECTION 14:
Check appropriate box (check one box only) to indicate the type of Qualifying Event.

SECTION 15:
Enter covered spouse information.

SECTION 16:
Provide information if the Qualified Beneficiary has dependents covered, and residing at a different address from Qualified Beneficiary.

PLEASE BE SURE TO COMPLETE ALL ITEMS AND TO SIGN AND DATE FORM. INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.