STERLING ADMINISTRATION

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COBRA QUALIFYING EVENT FORM

WE MAKE THE COMPLEX SIMPLE

This form is to be filled out by the employer or their representative and submitted to Sterling within **30 days** of the qualifying event or loss of coverage. Notification is **required** even if the Qualified Beneficiary advises the employer that he or she does not wish to continue coverage through COBRA.

Company Name: _____ Date Submitted: _____

Employee Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Gender: ☐ Male ☐ Female

Please list the names, social security numbers and birth dates for any other covered family members.

DEPENDENT NAME	SSN	BIRTH DATE	RELATIONSHIP

QUALIFYING EVENT INFORMATION

Qualifying Event Date: _____

Date Active Coverage Terminates: _____

Type of COBRA Event (check one)

☐ Involuntary Termination (fired, layoff, reduction in workforce)

☐ Voluntary Termination / Resignation / Retirement

☐ Reduction of Hours (full-time to part-time, unpaid leave of absence)

☐ Death of Employee (spouse and dependent children only)

☐ Divorce or Legal Separation (spouse and dependent children only)

☐ Loss of Dependent Status (dependent children only)

CURRENT ELIGIBLE BENEFITS

BENEFIT	CARRIER	TYPE (SINGLE, FAMILY, ETC.)	MONTHLY PREMIUM	ORIGINAL EFFECTIVE DATE

Medical HRA? ☐ Yes ☐ No

Medical FSA? ☐ Yes ☐ No Monthly Contribution Amount: _____

Hire Date (mm/dd/yyyy): _____

NOTES

Form Completed By: _____

Name (Print): _____

Date: _____ Phone: _____ Fax: _____

Signature: _____