PHBP
Producers' Health Benefits Plan

c/o BeneSys Administrators
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COBRA QUALIFYING EVENT FORM

This form is to notify the plan of COBRA qualifying events.
BeneSys will handle administration of Federal COBRA

Important
This form must be submitted to BeneSys no later than the date of the qualifying event.
Kindly fax to 925-478-4839

Employer Name: _____

Employee Name:	**Last Four Digits of SS #**	**Date of Termination: (Qualifying Event)**
_____	_____	_____

Employee Address: _____

Employee Personal Email: _____

Please check the qualifying event:

_____ Termination of employment for reasons other than gross misconduct; Reduction of the employee's hours (working under 30 hours, going on leave or expiration of FMLA period);

_____ Death of the employee;

_____ Spouse's divorce or legal separation from employee;

_____ Employee's entitlement to Medicare;

_____ Cessation of a child's dependent status under the terms of the plan (child dependent turns 26).

Name: _____

Employer Signature: _____ **Date:** _____

This form is to be completed by the employer for notification purposes only