COBRA NOTIFICATION FORM

Insurance Management Services
P O Box 15688
Amarillo, TX 79105

RE: COBRA Notification

Please proceed with notification of COBRA benefits for the following eligible beneficiaries:

Employee Name: _____
Employer Group & Division: _____
Social Security Number: _____ **Phone:** _____
Address: _____
Address2: _____
City: _____ **State:** _____ **Zip:** _____

Coverages	None	E/O	E/S	E/C	E/F	Term Date
Medical						
Dental						
Vision						

Qualified Beneficiaries:

Name: _____ **Name:** _____
Address: _____ **Address:** _____
_____ _____
_____ _____
Is this person disabled? _____ **Is this person disabled?** _____

Name: _____ **Name:** _____
Address: _____ **Address:** _____
_____ _____
_____ _____
Is this person disabled? _____ **Is this person disabled?** _____

Name: _____ **Name:** _____
Address: _____ **Address:** _____
_____ _____
_____ _____
Is this person disabled? _____ **Is this person disabled?** _____

Name: _____ **Name:** _____
Address: _____ **Address:** _____
_____ _____
_____ _____
Is this person disabled? _____ **Is this person disabled?** _____

Reason for notification of the qualifying event:

- ☐ **Death of Employee**
- ☐ **Terminated Employee**
- ☐ **Dependent Child no longer eligible**
- ☐ **Divorce**
- ☐ **Reduction of Employee hours**
- ☐ **Lay Off**

Date of the above qualifying event: _____

Signature: _____