COVERAGE CONTINUATION NOTICE (COBRA)

Please complete and send to CHP within 30 days of event, along with the termination application.

EMPLOYER INFORMATION:

Name of Employer: _____

EMPLOYEE INFORMATION:

Employee Name (Last, First, Middle): _____

Social Security #: _____

Last Known Address: _____

_____

COBRA QUALIFYING EVENT INFORMATION:

Qualifying event resulting in termination of coverage:

- ( ) Involuntary Termination (excluding gross misconduct)
- ( ) Voluntary Termination
- ( ) Reduction in hours resulting in loss of coverage
- ( ) Legal separation or divorce
- ( ) Employee entitled to Medicare
- ( ) Death of employee
- ( ) Dependent child ceasing to be eligible dependent

Date of qualifying event (Actual Date of Termination): _____

Date of coverage termination: (Last day of month of qualifying event): _____

ELECTION / DECLINE

Please indicate whether the employee and/or qualified beneficiaries would like to elect or decline COBRA coverage. Note: If electing coverage, an election notice will be sent and must be signed & returned, along with payment, to County Technical Services, Inc. in order for claims to be processed.

☐ **Elect** ☐ **Decline** ☐ **Undecided / Unknown**

Completed by: _____ **Date:** _____

Title: _____