Florida Blue
In the pursuit of health®

Continuation of Coverage QUALIFYING EVENT

RETURN TO: Florida Blue • P. O. Box 45272 • Jacksonville, Fl 32232-5272 • 1-855- 509-1678.

PLEASE CHECK ONE BOX ❑ ORIGINAL NOTICE ❑ REVISION to a form that was previously sent

1) Group Employer Name

2) Group Account Number

3) Please be advised that the following has had a Qualifying Event. (check one)
❑ Employee ❑ Dependent

4) Social Security Number of Qualified Beneficiary
_____

5) Employee # (if applicable)

6) Qualified Employee Name
_____
Last, First, Middle
_____
Street (include apartment number)
_____
City State Zip Code

7) Home Phone # of Qualified Beneficiary (include Area Code)
_____

8) If the Qualified Beneficiary listed in box #6 is not the employee, enter the following: Employee SSN _____
Dependent's Relationship to Employee _____

9) Date of Birth of Qualified Beneficiary
_____

10) Gender (check one)
❑ Male ❑ Female

11) Qualifying Event Date _____

12) Benefit Termination Date (cannot be prior to Qualifying Event Date)
_____

13) Is this a second Qualifying Event for a dependent who is currently on COBRA? ❑ No ❑ Yes

14) If employee, does he/she have a health care FSA?
❑ No ❑ Yes, MONTHLY contribution $_____

15) Enter the current Plan Number for the coverage(s) in effect on the day before the Qualifying Event Date:

	Plan Number*		Plan Number*
Medical	_____	**Vision**	_____
Dental	_____	**Other**	_____

* Only applicable if - tells group/member dental/vision is only available if offered by the group.
Note: Domestic partners and their dependents are not considered COBRA qualified beneficiaries. Please call us at 1- 800-876-2227 for plan options.

16) COBRA Qualifying Event that caused loss of coverage (check one)

Continuation of coverage for 18 months:
❑ Employee's retirement
❑ Employee's reduction in hours
❑ Employee's resignation
❑ Employee's layoff
❑ Employee's involuntary termination
❑ Employee's begins leave of absence

Continuation of coverage for 36 months:
❑ Divorce/legal separation
❑ Ineligibility of dependent child
❑ Covered employee/retiree becomes entitled to Medicare effective date of Medicare entitlement dependents may elect continuance of coverage _____
❑ Death of covered employee /retiree
❑ Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings by sponsoring employer under title 11 (bankruptcy) United States Code (Code 7)

17) Spouse/Dependent Information. Each name should include last, first and middle initial.
Name of Spouse_____
Social Security Number _____
Date of Birth _____
Gender ❑ Male ❑ Female
Address (if different from participant) _____

Dependent #1
Name of Dependent_____
Social Security Number _____
Date of Birth _____
Gender ❑ Male ❑ Female
Address (if different from participant) _____

Dependent #2
Name of Dependent_____
Social Security Number _____
Date of Birth _____
Gender ❑ Male ❑ Female
Address (if different from participant) _____

Dependent #3
Name of Dependent_____
Social Security Number _____
Date of Birth _____
Gender ❑ Male ❑ Female
Address (if different from participant) _____

Dependent #4
Name of Dependent_____
Social Security Number _____
Date of Birth _____
Gender ❑ Male ❑ Female
Address (if different from participant) _____

Prepared By
Name: (PRINT)_____
Date: _____
Telephone # _____
Fax # _____

Health coverage is offered by Blue Cross and Blue Shield of Florida, D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.