SELECT ONE

☐ **Notification of COBRA Qualifying Event**
or
☐ **New Health Plan Participant Notification**
or
☐ **Change** – Tier Changes / Employee **Dropping** Coverage- Submit to have participant removed from bill

NOTIFICATION FORWARDING OPTIONS: Email: COBRA@AdminAmerica.com
***OR SELF-SERVICE OPTION THROUGH*: cobra.adminamerica.com**

COMPANY	GWINNETT EMERGENCY SPECIALISTS	ADMIN AMERICA CODE
		GES

EMPLOYEE DATA (LAST KNOW ADDRESS REQUIRED)
PLEASE VERIFY ACCURACY ON THIS FORM EMPLOYER WILL BE BILLED $10.00 REPROCESSING FEE

DATE OF HIRE:

Name:			
SSN:		**DOB:**	
Home Address:			
Gender: ☐ M ☐ F	City	ST	Zip Code

FOR NEW PARTICIPANTS

NEW COVERAGE BEGINS:

COBRA QUALIFYING EVENT DATES

EVENT DATE (DOT, DIVORCE, REDUCED HRS, ETC…) :

LAST DAY OF COVERAGE (ON EMPLOYER'S PLAN) :
TPA MUST BE NOTIFIED OF TERMINATIONS WITHIN 30 DAYS.
LATE NOTICE MAY RESULT IN CARRIER(S) REFUSAL TO REINSTATE COBRA

PLAN(S) EMPLOYEE ENROLLING IN OR TERMING FROM	
MEDICAL	☐ **Aetna NPOS HSA** ☐ **Aetna NPOS Silver Opt 1** ☐ **Aetna NPOS Silver Opt 2**
DENTAL	☐ **UCCI**

Comments:

QUALIFYING EVENT
***Involuntary Termination** will be assumed if no event is selected*

TERMINATION OF EMPLOYMENT:
- ☐ Voluntary
- ☐ Involuntary*
- ☐ ***Involuntary- due to gross misconduct***
  Member will be sent a denial of COBRA Notice
  ***DO NOT SELECT* this option without consulting Legal Counsel**

- ☐ **Death of Employee**
- ☐ **REDUCTION OF WORK HOURS**
- ☐ **LOSS OF "DEPENDENT CHILD" STATUS**
- ☐ **DIVORCE**
- ☐ **LEGAL SEPARATION**

COMMENTS:

☐ **SEVERANCE PACKAGE TO INCLUDE BENEFITS**

Is the continuation under severance to be considered Employer-subsidized COBRA, or is COBRA to begin following Severance?

☐ COBRA part of Severance ☐ COBRA to begin after Severance

Coverage to be paid by Employer thru: _____

Did you notify the insurance carrier(s) to cancel the coverage at the End of Severance ***or*** was the date left open-ended?

☐ **End of Severance** ☐ **Open-Ended**

DEPENDENTS / QUALIFIED BENEFICIARIES - PROVIDE ADDRESS IF DIFFERENT THAN EMPLOYEE NAMED ABOVE

RELATIONSHIP	NAME(S)	DOB	GENDER	SELECT COVERAGE(S) MEDICAL	DENTAL	VISION
☐ Spouse			☐ M ☐ F	☐	☐	☐
☐ Child 1			☐ M ☐ F	☐	☐	☐
☐ Child 2			☐ M ☐ F	☐	☐	☐
☐ Child 3			☐ M ☐ F	☐	☐	☐
☐ Child 4			☐ M ☐ F	☐	☐	☐
☐ Child 5			☐ M ☐ F	☐	☐	☐
☐ Child 6			☐ M ☐ F	☐	☐	☐