COBRA Employer Notice of Qualifying Event

For fastest processing, submit this form online via support request. You may also use one of the following methods:	Fax	Mail
	608-245-3623	TASC, PO Box 14015 Madison, WI 53708-0015

CLIENT/EMPLOYER INFORMATION

Client/Employer Name:			
Division:		TASC ID (12-digit):	
Client/Employer Email:		Client/Employer Phone:	

PARTICIPANT INFORMATION

Employee's First Name:		MI:		Last Name:	
Participant's First Name: *(if different than Employee)*		MI:		Last Name:	
SSN: *(Only enter if TASC will perform Carrier Notification services.)*				Date of Birth:	
Gender:	☐ Female ☐ Male ☐ Other			Marital Status:	☐ Married ☐ Single
Primary Address:	Address 1:			Apt:	
	Address 2:				
	City:				
	State:	ZIP Code:		+4:	

QUALIFYING EVENT INFORMATION

Qualifying Event Date:		COBRA Start Date:	
Select one of the following QE Types:	☐ Involuntary termination of employment ☐ Cessation of dependent status ☐ Death of employee ☐ Divorce or legal separation from employee	☐ Voluntary termination of employment ☐ Reduction in hours of employment ☐ Start of employer bankruptcy proceeding	

SEVERANCE INFORMATION

Complete if employer is subsidizing all / a portion of COBRA premium as part of a severance agreement with the Qualified Beneficiary.					
Adjusted Dollar Amount:		or % Paid by Employer:		Severance End Date:	

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PLAN INFORMATION

Indicate the level of coverage for each plan the participant was enrolled in as of the Qualifying Event date:						
Coverage Type:	**Name and Option of Benefit Plan** e.g., PPO or HMO *(if applicable)*	**PQB Only**	**PQB & Spouse**	**PQB & 1 Child**	**PQB & Family**	**PQB & Children**
HEALTH						
DENTAL						
VISION						
OTHER:						

FSA Annual Election Amount:		Claims Paid To Date:	
Employee Contribution:		FSA Plan Year End Date:	

DEPENDENTS COVERED

LAST NAME	FIRST NAME	RELATIONSHIP TO INDIVIDUAL	DATE OF BIRTH	GENDER	SSN *(only enter if TASC will perform Carrier Notification services)*

SUBMITTED BY

Print Name _____ **Title** _____

Signature _____ **Date** _____