

EMPLOYER'S COBRA NOTICE

On _____ the following employee and/or dependents had the noted qualifying event¹.

(actual date of event)

COBRA effective date will be _____.

(must be last day of month of actual date or first of month following actual date)

The following employee and/or dependents are eligible for continuation of health care benefits under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

Employee: _____ **SS#** _____ **B-day** _____

Spouse: _____ **SS#** _____ **B-day** _____

Dependents: _____ **SS#** _____ **B-day** _____

Dependents: _____ **SS#** _____ **B-day** _____

Dependents: _____ **SS#** _____ **B-day** _____

Send Cobra Notice & Invoicing to:

Address: _____

City, State Zip: _____

¹The following event activates eligibility (please check one):

- | | |
|---|--|
| <input type="checkbox"/> Termination of Employment* | <input type="checkbox"/> Medicare Eligibility*** |
| <input type="checkbox"/> Retirement* | <input type="checkbox"/> Divorce or Legal Separation*** |
| <input type="checkbox"/> Reduction in Hours* | <input type="checkbox"/> Child's Loss of Dependent Status*** |
| <input type="checkbox"/> Termination due to 100% Disability** | <input type="checkbox"/> Death of employee*** |

* = 18 months extension ** = 29 months extension *** = 36 months extension

Type of Membership: Single Couple Parent/Child Family

Plans: POS501 POS502 POS503 HMO601 HMO602 HMO603 HD1 HD2 HD801 HD802

Dental: 409-2 409-3 495-8 495-9 496-0 NONE
Circle one

Vision: Yes No
Circle one

TERMINATION: **INVOLUNTARY** **VOLUNTARY**

Circle one

Company Name

Date

Return form to: NHMTA-Employee Benefit Trust
PO Box 3898
Concord, NH 03302-3898