

# Catholic Diocese of Jackson

## Health Insurance Program

### Notification of COBRA Qualifying Event / Termination of Benefits

\_\_\_\_\_  
**Name of Employee** \_\_\_\_\_ **Health Insurance ID # or SS#**

\_\_\_\_\_  
**Employer - School/Parish or Other** \_\_\_\_\_ **City/Town** \_\_\_\_\_ **Location #**

\_\_\_\_\_  
**Qualifying Event Date**

#### Qualifying Events Pertaining to Employee:

\_\_\_\_\_  
Employee's Resignation/Termination \_\_\_\_\_ Employee Long Term Disability  
\_\_\_\_\_  
Employee's Retirement \_\_\_\_\_ Employee's Reduction of Hours  
\_\_\_\_\_  
Employee Layoff/Involuntary Termination \_\_\_\_\_ Employee's Death  
\_\_\_\_\_  
Employee Became Medicare Eligible \_\_\_\_\_ Other: \_\_\_\_\_

<u>Coverage Type</u>	<u>Medical</u>	<u>Dental</u>	<u>Vision</u>	<u>GAP</u>	<u>FSA</u>
Employee Only / EE	_____	_____	_____	_____	_____
Employee Spouse / ES	_____	_____	_____	_____	_____
Employee Child(ren) / EC	_____	_____	_____	_____	_____
Employee Family / EF	_____	_____	_____	_____	_____

#### Qualifying Events Pertaining to Dependents

\_\_\_\_\_  
Divorce/Legal Separation from Covered Employee  
\_\_\_\_\_  
Ineligible Dependent Child  
\_\_\_\_\_  
Death of Covered Employee

\_\_\_\_\_  
**Names of Dependents**

\_\_\_\_\_  
**Employer Representative** \_\_\_\_\_ **Date**

Completed form must be sent to Phyllis Mokry and Donna Vecellio