Benecom Company

Benecom Company
Third Party Administrators
3429 Stony Spring Circle
Louisville, KY 40220
(502)499-2501 ◆ (888)739-8587
Fax (502)495-6825 ◆ Email: JNK4466@aol.com

COBRA
Employee Termination Notification

Employee Personal Information

Employee Name: ________________________ Social Security Number: ______—______—______

Address: ________________________ City, State, Zip ________________________

Telephone: ( ) ________________ Date of Birth ____________ Date of Hire ____________

Qualifying Event Date: ____________ Loss of Coverage Date: ____________ Severance Agreement ____________

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss Gender: ☐ Male ☐ Female

Qualifying Event: ☐ Terminated ☐ Reduction of Hours ☐ Quit ☐ Retired ☐ Other: ________________

Dependant Information

Name: ________________________ Relationship: ____________ Date of Birth ____________

Address: ________________________ City, State, Zip ________________________

Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No

Name: ________________________ Relationship: ____________ Date of Birth ____________

Address: ________________________ City, State, Zip ________________________

Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No

Name: ________________________ Relationship: ____________ Date of Birth ____________

Address: ________________________ City, State, Zip ________________________

Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No

Name: ________________________ Relationship: ____________ Date of Birth ____________

Address: ________________________ City, State, Zip ________________________

Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No Vision: ☐ Yes ☐ No

Plan Information

Health	Dental	Vision	Other
☐ Employee Only	☐ Employee Only	☐ Employee Only	☐ FSA
☐ Employee + Spouse	☐ Employee + Spouse	☐ Employee + Spouse	Contributed__________
☐ Employee + Child(ren)	☐ Employee + Child(ren)	☐ Employee + Child(ren)	Disbursed__________
☐ Family	☐ Family	☐ Family	☐ HRA
			Benefit Amount________

I certify that the above noted information is correct and the individual(s) have incurred a qualifying event and are now eligible for COBRA. I have notified the Plan Administer (Benecom) within the allotted 30 day grace period in order for the COBRA Administrator to proceed with notifying the qualified beneficiary within the required timeframe.

Company Name: ________________________ Date: ________________

Employer Representative Signature: ________________________