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
Active/Pending Takeover Form

Participant Personal Information

☐ Participant was an employee ☐ Participant was a dependant

Name: _____ Social Security Number: _____—_____—_____

Address: _____ City, State, Zip _____

Telephone: ( ) _____ Date of Birth ____/____/_____ Date of Hire ____/____/_____

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

Qualifying Event Date: ____/____/_____ Loss of Coverage Date: ____/____/_____

Eligible for / Receiving AARA Subsidy Reduction: ☐ YES ☐ NO If NO explain _____

☐ Active COBRA : Elected Coverage on ____/____/_____ and payment has been paid thru ____/____/_____

☐ Elected COBRA: Notice was sent on ____/____/_____ and Elected Coverage on ____/____/_____

☐ Pending COBRA: Notice was sent on ____/____/_____

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

Plan Information

Health	Dental	Vision	Previous Carrier
☐ Employee Only	☐ Employee Only	☐ Employee Only	Carrier Name
☐ Employee + Spouse	☐ Employee + One	☐ Employee + One	Medical _____
☐ Employee + Child(ren)	☐ Family	☐ Family	Dental _____
Family			Vision _____

Company Name: _____ Date: _____

Employer Representative Signature: _____