COBRA – Notice to Plan Administrator

[Date]

To:
[Name]
[Title]
[Company]
[Address]
[City, State, Zip]

From:
[Name]
[Title]
[Company]
[Address]
[City, State, Zip]

The following covered employee may require COBRA continuation coverage due to the listed qualifying event.

[Plan Name]
[Covered Employee Name]
[Address]
[City, State, Zip]

Qualifying Event: Date of Qualifying Event: _____

☐ Death

☐ Reduction in hours

☐ Termination

☐ Divorce

☐ Legal Separation

☐ Loss of dependant status

☐ Other _____

_____
[Signature of Employee Representative]