Active COBRA Participant Form

(Use this form to notify CPI of any current COBRA participants you may have.)

Company Name:_____

Division and/or Address:_____

Participant Name:_____

Address: _____ City/State/Zip: _____

Social Security #: _____ Date of Birth: _____ Sex: ☐ M or ☐ F

Date of Hire: _____ ☐ Employee or ☐ Dependent Event: _____
Employee Name & SSN if Dependent Event

Qualifying Event Date:_____ **Date COBRA began**: _____

Date Notified of COBRA Rights: _____ Date COBRA elected: _____

Last Month Premium was Paid: _____

Category "A"
- ☐ Termination of Employment
- ☐ Reduction of Hours
- ☐ Employer's Bankruptcy

Category "B"
- ☐ Divorce or Legal Separation
- ☐ Dependent Child's loss of dependent status
- ☐ Death of Covered Employee
- ☐ Covered Employee's Medicare Entitlement

Benefits Elected for Continuation:

	Y	N	Plan Name	Level of Coverage (Please check the level of coverage.)			
Health	☐	☐	_____	☐ EE Only	☐ EE + Spouse	☐ EE + Dep(s)	☐ Family
Dental	☐	☐	_____	☐ EE Only	☐ EE + Spouse	☐ EE + Dep(s)	☐ Family
Vision	☐	☐	_____	☐ EE Only	☐ EE + Spouse	☐ EE + Dep(s)	☐ Family
FSA/HRA	☐	☐	_____	☐	Plan Year End Date		

Please list all beneficiaries/dependents.

Name	Relationship	Date of Birth	Social Security #	Benefits in Place Before Event

If anyone listed above has a mailing address different from the employee, please provide the address and indicate which individual should receive correspondence at that address: _____

Comments: _____

Prepared by: _____ **Today's Date**: _____

www.mycpiteam.com
6421 Perkins Road, Bldg A Ste 2A; Baton Rouge, LA 70808
Phone: (225) 215-2203 Fax: 225-706-0280 Phone: 866-241-0237 (Toll Free)

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