

COBRA Event Notice

Please complete this form to communicate a COBRA event.

Employer: **City of Albany** Medical Plan: _____

Employee Name: _____ Employee ID #: _____

I am reporting (check one of the following): A change form must be completed for Insurance Company(s).

Divorce (Dissolution of marriage) Divorce Decree Date: _____

Termination Dissolution or annulment of domestic partnership
Legal Dissolution Date: _____

A dependent child who ceases to meet plan's definition of dependent child

Date child is not a dependent: _____

Date Coverage Lost: _____

Social Security Administration Determination of Disability or No Longer Disabled

Disability Date: _____ No Longer Disabled Date: _____

You must supply evidence of the event.

Qualifying Event	Acceptable Evidence	Length of Time to Report
Dissolution of Marriage	Signed Divorce Decree	Within 60 Days
Termination, Dissolution, or Annulment of Domestic Partnership	COBRA Event Notice Form (this document)	Within 31 Days
Dependent Child	COBRA Event Notice Form (this document)	Within 60 Days

Except in the case of a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or a copy of the determination that you are no longer disabled.

Name(s), address, and phone of persons losing coverage because of event:

I declare that I am the covered employee or person who experienced the event or representative of either and certify that the above event has occurred as represented.

Signature: _____ Date: _____

This form must be submitted to:

Danette DeSaulnier
Human Resources
333 Broadalbin Street SW
Albany, OR 97321

Please keep a copy for your files.