OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division

COBRA QUALIFYING EVENT NOTICE

To be completed by the insurance/benefits coordinator at the time of a COBRA Qualifying Event and sent to the Employees Group Insurance Division.

Employee name _____ SSN _____

Mailing address _____ City _____ State _____ ZIP _____

Employer name _____ Agency or group number _____

Insurance/benefits coordinator name _____

Insurance/benefits coordinator phone _____

Date _____ Is this employee eligible to vest/retire? Yes* ☐ No ☐

***Insurance/benefits coordinator: If yes, explain the options of both vesting/retirement and COBRA so the member can make an informed choice.**

This employee and/or dependent(s) is entitled to continuation of coverage for the following reason (COBRA qualifying event):

☐ Termination date _____ Last day of employee insurance coverage _____

- ▶ Was employee involuntarily terminated? Yes ☐ No ☐
- ▶ Was employee terminated for gross misconduct? Yes ☐ No ☐
- ▶ Was employee called to military duty (USERRA)? Yes ☐ No ☐

☐ Reduction of work hours – date _____

☐ Death date _____

☐ No longer an eligible dependent as of date _____

- ▶ Reason dependent is not eligible **(required)** _____

Name and current mailing address of ineligible dependent(s):

_____

_____

_____