

ATTN: Lucy Vieira

FAX # 315-471-4960

COBRA Dept.

# Vermont State Dental Society

## COBRA NOTIFICATION FORM

( Please print clearly )  
COBRA Qualifier

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

Current Coverage: ( Circle )  
**MEDICAL**

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Single Double Family

EE Original Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

EE Benefit Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Name: \_\_\_\_\_

Member #: \_\_\_\_\_

(If different than the COBRA Qualifier identified above)

Dependent Information		
Name	Relationship	D.O.B.

Please check type of qualifying event:

Termination of Employment

Divorce/Separation

Reduction in hours

Death of Employee

Medicare eligibility

Dependents loss of eligibility

Date of Benefits Termination: \_\_\_\_\_

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date form completed