



## **COBRA/State Continuation Services Service Contract**

### **INSTRUCTIONS:**

**To activate this service, read agreement and sign the Signature Page, and return it to CBIA.**

CBIA COBRA / State Continuation Services  
350 Church Street  
Hartford, CT 06103-1126

**In addition, if you have former employees and/or dependents currently enrolled in COBRA / State Continuation, you'll need to complete and return a Continuant Takeover Form, also included in this package.**

**CBIASC SERVICE CORP –  
COBRA/STATE CONTINUATION-OF-COVERAGE  
SERVICE AGREEMENT**

**SIGNATURE PAGE**

**(Client – Please return the page completed in the enclosed postage paid envelope to CBIA Service Corp, COBRA Administration Services, 350 Church Street, Hartford, CT 06103-1126), or fax it to: CBIA COBRA Services, (860)278-0883**

I have read this Agreement and agree to the terms and conditions herein.

CLIENT NAME: \_\_\_\_\_

CLIENT ADDRESS: \_\_\_\_\_

\_\_\_\_\_

Signed by: \_\_\_\_\_

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

(Print)

Title: \_\_\_\_\_

(Print)

Date of Signature: \_\_\_\_\_

Client's Requested Date for CBIASC to start Services: \_\_\_\_\_

\_\_\_ I do not have any existing COBRA/State Continuation-of-Coverage continuants.

\_\_\_ I do have existing COBRA/State Continuation-of-Coverage continuants, who I am transferring to CBIASC for Services through the attached Continuant Takeover Form. (See Appendix A)

CBIA SERVICE CORP., INC.  
350 Church Street  
Hartford, CT 06103-1126

\_\_\_\_\_  
Philip Vogel  
Senior Vice President

EFFECTIVE DATE: \_\_\_\_\_

**CBIA SERVICE CORP.**

**COBRA / STATE CONTINUATION-OF-COVERAGE  
SERVICE AGREEMENT**

AGREEMENT dated \_\_\_\_\_, between \_\_\_\_\_ (“Client”) with offices at \_\_\_\_\_, and CBIA SERVICE CORP., Inc., (“CBIASC”), with offices located at 350 Church Street, Hartford, CT 06103. Without notice of cancellation, this Service Agreement is automatically renewed for a twelve (12) month period.

In consideration of the mutual promises contained herein, Client and CBIASC agree as follows:

**I. SERVICES and RESPONSIBILITIES.**

**A. CBIASC SERVICES**

1. Client (for itself and on behalf of its plan administrator) hereby retains CBIASC to provide, and CBIASC hereby agrees to provide, the following non-discretionary, ministerial record-keeping and notification services (the “Services”) as described below:
  - a. Creation and mailing of initial COBRA/State Continuation-of-Coverage notification to Client’s employees and dependents when they first become eligible for coverage through Client’s health and/or dental plan(s) offered through CBIASC.
  - b. Creation and mailing of COBRA/State Continuation-of-Coverage notice and election form to Qualified Beneficiaries (QBs), as defined in Section II. A., immediately following a Qualifying Event, as defined in Section II. B., herein.
  - c. Enrollment in COBRA/State Continuation of Coverage benefits of QBs who elect COBRA/State Continuation-of-Coverage.
  - d. Creation and mailing of monthly premium bills to COBRA/State Continuation-of-Coverage enrollees (“Enrollees”).
  - e. Provision of telephone information and support regarding eligibility, enrollment and billing to QBs and Enrollees.
  - f. Notification to Enrollees of the termination of COBRA/State Continuation-of-Coverage benefits.
  - g. Notification to Enrollees of renewal, changes or termination of Client’s health and/or dental plan(s).
  - h. Transmission of premiums received from Enrollees to health and/or dental insurance carriers.
  - i. Communication of QB enrollment and disenrollment to health and/or dental insurance carriers.
2. CBIASC shall not be required to provide the Services herein enumerated until the Effective Date, which shall be the Effective Date designated by CBIASC on the Signature Page of this Agreement. In no case shall the

Effective Date designated by CBIASC be sooner than the date the Client signs and returns the Signature Page of this Agreement to CBIASC at the address shown.

## B. CLIENT RESPONSIBILITIES

1. CBIASC COBRA/State Continuation-of-Coverage Services require Client to perform, and Client agrees to perform, the following responsibilities:
  - a. Make available to COBRA/State Continuation-of-Coverage Enrollees the same health and dental options as are available to Client's current employees and dependents.
  - b. Complete and return to CBIASC the Continuant Takeover Form (Appendix A) for any existing COBRA/State Continuation-of-Coverage continuants.
  - c. Notify CBIASC when employees or dependents first become eligible for coverage under Client's health and/or dental plan, within 31 days of the effective date of coverage under the plan(s).
  - d. Notify CBIASC when employees or dependents experience a COBRA/State Continuation-of-Coverage Qualifying Event as defined in Section II, by completing and mailing to CBIASC a Qualifying Event Form (Appendix B) within 14 days of the Qualifying Event effective date.
  - e. Notify CBIASC of any changes in, or termination of, Client's health and/or dental plan(s) within 15 days of the change or termination.
  - f. Notify CBIASC in the event of any sale, transfer, merger or acquisition of Client's business, or if Client files for federal bankruptcy.
2. Client understands that as a condition of CBIASC providing the Services enumerated in Subsection A., Client shall timely and accurately perform all of the enumerated Responsibilities and provide the information required in this Agreement and any amendments thereto. CBIASC reserves the right to request additional information from Client at any time. CBIASC shall be entitled to rely on any information provided by the Client as accurate, valid and complete.

## C. AMENDMENTS TO SERVICES AND RESPONSIBILITIES

CBIASC and Client understand that the Services and Responsibilities herein enumerated are requirements and procedures dictated by federal COBRA and State Continuation-of-Coverage laws. If the requirements and procedures are changed by law, CBIASC will amend this Agreement to incorporate the changes in the law and provide such amendments ("Amendments") to the Client. Client will be deemed to have accepted and approved each Amendment thereto if Client does not promptly notify CBIASC in writing that it objects to any provision of the Amendment thereto.

## II. DEFINITIONS

- A. **Qualified Beneficiary (QB)** – The employee and/or dependent(s) who are covered under an employer health and/or dental plan on the day before a Qualifying Event.
- B. **Qualifying Event (QE)** – Any of the occurrences listed below, which cause an employee and/or dependent(s) who are covered under an employer health and/or dental plan to be disqualified from group coverage, are Qualifying Events. Client agrees to notify CBIASC whenever any of Client's employees or dependents

experience any one of the following Qualifying Events by completing and mailing a Qualifying Event Form (Appendix B) to CBIASC within 14 days of the Qualifying Event:

1. An employee terminates employment for any reason (other than, in certain circumstances, for gross misconduct), including voluntary termination.
2. An employee experiences a reduction of work hours, including work stoppage and non-FMLA leave-of-absence.
3. An employee and spouse experience a divorce or legal separation, disqualifying the spouse from dependent coverage.
4. A child ceases to qualify for dependent coverage because the child:
  - reaches age 26; or
  - has an offer of coverage from their employer
5. A dependent ceases to qualify for dependent coverage because an employee becomes entitled to Medicare.
6. If the Client declares bankruptcy under Chapter 11, this is a qualifying event to any retirees (and their dependents) who are covered by the Client's health and/or dental plan.

NOTE: In addition, if a dependent Enrollee experiences a second Qualifying Event, the dependent may be eligible for a total of 36 months of COBRA/State Continuation-of-Coverage measured from the date of the first Qualifying Event.

### **III. DISCLAIMER.**

- A. CLIENT ACKNOWLEDGES THAT THE PERFORMANCE OF SERVICES BY CBIASC DOES NOT AND IS NOT INTENDED TO MAKE CBIASC THE "PLAN ADMINISTRATOR," "PLAN SPONSOR," OR OTHER "FIDUCIARY" UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974, AS AMENDED, OR OTHERWISE OF ANY PLAN, AND CLIENT WILL NOT IDENTIFY OR REFER TO CBIASC OR ANY OF ITS AFFILIATES AS SUCH. CBIASC HAS NO DISCRETIONARY AUTHORITY OR DISCRETIONARY RESPONSIBILITY IN THE ADMINISTRATION OF THE CLIENT'S HEALTH AND/OR DENTAL PLAN(S). The parties further acknowledge and agree that CBIASC will not be deemed to be providing legal or tax advice to Client as a result of the ministerial duties undertaken by CBIASC pursuant to this Agreement.
- B. Client shall not use CBIASC's or its affiliates' names or marks without CBIASC's prior written consent.

### **IV. FEES, TAXES, PAYMENTS.**

- A. Client understands and agrees that CBIASC will bill the QB who CBIASC enrolls for COBRA/State Continuation-of-Coverage benefits, as follows:
  1. The premium due for coverage; and,
  2. An Administrative Fee computed as 2% of premium, as permitted by state and federal law.

- B. Client acknowledges that CBIASC will retain the Administrative Fee as compensation for Services rendered hereunder.

**V. LIABILITY AND INDEMNIFICATION.**

- A. CBIASC shall not have any obligation or liability with respect to any Services before the Effective Date of this Agreement, including notices and the collection and remission of premiums.
- B. CBIASC shall not have any obligation to verify or determine the accuracy, validity or completeness of information provided by Client or its plan administrator, and shall not be responsible for errors, delays or additional costs resulting from the receipt of inaccurate, invalid, incomplete or untimely information or information provided in an unacceptable format or media. Client and/or its plan administrator agree to provide any and all information to CBIASC on a timely basis.
- C. In the event of an error in CBIASC's records or any reports or statements prepared by CBIASC and caused by CBIASC, CBIASC shall correct such records, reports or statements, provided that Client advises CBIASC of such error within 30 days of the receipt of such record, report or statement.
- D. CBIASC is not required, under the terms of this Agreement, to review any action of Client or its plan administrator(s). Furthermore, CBIASC will not incur any liability by taking, permitting or omitting any actions on the basis of any action of Client or its plan administrator or for carrying out the directions of Client or its plan administrator.
- E. Client agrees to defend, indemnify and hold harmless CBIASC, its affiliates and their directors, officers, employees, legal representatives, agents, successors, and assigns from and against all claims, losses, liabilities, damages, demands, lawsuits, causes of action, costs and expenses (including reasonable attorneys' fees and costs) (collectively "Losses") as a result of entering into and performing services under this Agreement or any other cause arising out of this Agreement, except to the extent those Losses resulted from the gross negligence, willful misconduct or willful breach of this Agreement by CBIASC in the performance of the Services.
- F. CBIASC agrees to defend, indemnify, and hold harmless the Client and its plan administrator, and its officers, directors, shareholders, employees and agents (collectively the "Client Group") from and against all Losses asserted against or imposed on any member of the Client Group to the extent those Losses resulted from the gross negligence, willful misconduct or willful breach of this Agreement by CBIASC in the performance of the Services; provided, that (i) CBIASC is promptly notified in writing of such suit or cause of action; (ii) CBIASC controls any negotiations or defense and Client assists CBIASC as reasonably required by CBIASC; and (iii) Client takes all reasonable steps to mitigate any potential damages that may result. Notwithstanding the foregoing, CBIASC shall have no obligation under this Section 5.F. to the extent CBIASC is entitled to indemnification from Client pursuant to Section 5.E or CBIASC is otherwise not liable under this Section 5.
- G. IN NO EVENT WILL CBIASC BE RESPONSIBLE FOR SPECIAL, INDIRECT, INCIDENTAL, CONSEQUENTIAL OR OTHER SIMILAR DAMAGES IN CONNECTION WITH THE SERVICES, EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.
- H. CBIASC shall not be liable for any delay or failure to perform under this Agreement resulting, directly or indirectly, from strike, fire, war, insurrection, riot, power failure or a circumstance beyond CBIASC's reasonable control. In case of errors or lost data caused by power failure, mechanical difficulties with information storage and retrieval systems, or other events not attributable to its own negligence or willful

misconduct, CBIASC's sole obligation will be to use its reasonable efforts to reconstruct any records maintained by CBIASC and to amend any reports prepared by it which may have been affected by such event, at its own expense.

- I. This Section 5 sets forth the full extent of CBIASC's liability hereunder for any claim against CBIASC, and sets forth Client's sole remedies.

## **VI. TERM AND TERMINATION.**

- A. Either party may terminate this Agreement with 90 days prior written notice (or such earlier date as mutually agreed upon between the parties).
- B. Notwithstanding anything contained herein, if Client defaults in the performance of its obligations hereunder (including failure to follow the Client Responsibilities herein enumerated), CBIASC may, upon written notice thereof, terminate this Agreement.
- C. This Agreement shall automatically be terminated in the event Client ceases to be:
  - 1. A participating employer in a health or dental plan sponsored through the CBIA Health Connections Program or CBIA/Aetna Program; and,
  - 2. A CBIA member in good standing.
- D. This Agreement shall automatically be terminated in the event Client objects to any amendment thereto.
- E. Except as hereinafter provided, the termination of this Agreement shall not affect obligations arising prior to the termination of this Agreement.
- F. Upon termination of this Agreement, CBIASC shall have no further duties or responsibilities with respect to COBRA/State Continuation-of-Coverage requirements related to the Client's employees, dependents or COBRA/State Continuation-of-Coverage continuants, except CBIASC shall provide for a reasonable transfer of records from CBIASC to Client or its designee upon payment of a reasonable administrative fee, if any.

## **VII. CONFIDENTIALITY.**

- A. For purposes of this Section, "Confidential Information" shall mean: all information of a confidential or proprietary nature provided by the disclosing party to the receiving party for use in connection with the Services, but does not include (i) information that is already known by the receiving party without an obligation of confidentiality; (ii) information that becomes generally available to the public other than as a result of disclosure by the receiving party in violation of this Agreement; and (iii) information that becomes known to the receiving party from a source other than the disclosing party on a non-confidential basis. Confidential Information of CBIASC also includes all trade secrets, processes, proprietary data, information or documentation related thereto of CBIASC or its affiliates and any pricing or product information furnished to Client by CBIASC or its affiliates.
- B. All Confidential Information disclosed hereunder will remain the exclusive and confidential property of the disclosing party. The receiving party will not disclose the Confidential Information of the disclosing party and will use at least the same degree of care in protecting the Confidential Information of the disclosing party as it uses with respect to its own Confidential Information. The receiving party will limit access to

Confidential Information to its employees and advisors with a need to know and will instruct such employees and advisors to keep such information confidential. Notwithstanding the foregoing, the receiving party may disclose Confidential Information to the extent necessary to comply with any law, ruling, regulation or rule applicable to it or to the extent necessary to enforce its rights under this Agreement. In addition, CBIASC may also disclose Client Confidential Information (i) to the extent that disclosure of such information is required to perform the Services, and (ii) in connection with an audit or regulatory examination by a governmental authority.

### **VIII. COMPLIANCE WITH LAWS.**

CBIASC agrees to perform the Services for Client in accordance with a reasonable good faith interpretation of the applicable requirements of federal and state law. Except for such responsibilities assumed by CBIASC pursuant to this Agreement, Client shall be responsible for (i) compliance with all laws and governmental regulations (including state and federal health care continuation laws) affecting Client's business, and (ii) any use it may make of the Services to assist it in complying with such laws and governmental regulations.

### **IX. GENERAL.**

- A. This Agreement shall not be assigned by Client without the prior written consent of CBIASC, and any attempt to assign any rights, duties or obligations which arise under this Agreement without such consent will be void.
- B. Client has not been induced to enter into this Agreement by any representation or warranty not set forth herein. This Agreement contains the entire agreement of the parties with respect to its subject matter and supersedes all existing agreements and all other oral, written or other communications between them concerning its subject matter. This Agreement shall not be modified except by a writing signed by the parties.
- C. Client acknowledges, confirms and agrees that other than CBIASC's obligations to Client hereunder, CBIASC has no obligation to any third party (including any current or former qualified beneficiaries under Client's health and/or dental plan or any agent or other person associated with Client).
- D. Any notice under this Agreement shall be given in writing and hand delivered or mailed to the relevant party. Notices and payments sent by mail shall be deemed to have been mailed on the date of the postmark thereof. Notices shall be deemed received on the date of delivery if delivered in person and five business days after mailing if mailed. Any notice provided through an electronic medium shall be recognized to the extent provided in applicable law to the extent such notice is properly and timely transmitted.
- E. This Agreement shall be governed by the laws of the State of Connecticut, without regard to conflict of laws provisions.

# CBIA Service Corp. — COBRA/State Continuation Services

## CONTINUANT TAKEOVER FORM

APPENDIX A

(To transfer current COBRA/State Continuation continuants to CBIA Service Corp. — COBRA/State Continuation Services)

**INSTRUCTIONS: Please print clearly**

- Fill out just one form per family unit (Qualified Beneficiary and Dependents)
- Please do not use this form to report new Qualifying Events — use the COBRA/State Continuation Notification Form.
- Please see back side of this form for further instructions.

**COMPLETE THIS FORM AND RETURN IT TO:**

CBIA Service Corp. — COBRA/State Continuation Services  
 350 Church Street  
 Hartford, CT 06103-1126  
 Fax: 860-278-0883

**PLEASE CHECK ONE BOX:**    **Original notice** (If FAXED, do not mail copy)    **Revision...** to a form that was previously sent

|  |  |   |   |
|--|--|---|---|
| <b>1) From: (Company)</b> _____  |  | <b>2) CBIA Case Number</b> _____  |   |
| <b>3) Please be advised that the following is currently on COBRA/State Continuation.</b><br>(Check one box only) <input type="checkbox"/> (E)mployee <input type="checkbox"/> (D)ependent  |  | <b>4) Social Security Number of Qualified Beneficiary</b><br>_____ - _____ - _____  |   |
| <b>5a) Name of COBRA/State Continuation continuant (last, first, mi) (Please print)</b><br>_____   |  |   |   |
| <b>5b) Street Address</b> _____  |  | <b>5c) City</b> _____   | <b>5) State</b> _____   |
| <b>5e) ZIP Code</b> _____  |  |   |   |
| <b>6) Home Phone # (if available)</b><br>_____ - _____ - _____   |  | <b>7) Date of Birth of Qualified Beneficiary</b><br>____/____/____<br>M M D D Y Y Y Y   | <b>8) Gender</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female |
| <b>9) Marital Status (check one box only.)</b><br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | <b>15) Check the current plan code coverages. CBIA administers only plan code coverage options that are permitted by your plan or carrier. (check one box only.)</b><br><input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse<br><input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family  |   |
| <b>10) If the above individual in box #5 is a dependent of an employee/former employee, please complete the following:</b><br>Employee Name (last, first, mi) _____<br>Employee SSN _____ - _____ - _____<br>Dependent's relationship to Employee _____  |  |   |   |
| <b>11) Qualifying Event Date</b> _____<br>M M D D Y Y Y Y  |  |   |   |
| <b>12) Last day of pre-COBRA Coverage (cannot be prior to Qualifying Event Date)</b><br>_____ - _____ - _____<br>M M D D Y Y Y Y   |  | <b>16) At the time of the termination or reduction in hours, was the employee eligible to receive Social Security income?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  |   |
| <b>13) First premium due-date for which CBIA is to begin COBRA/State Continuation billing</b> _____<br>M M D D Y Y Y Y   |  | <b>17) If the COBRA/State Continuation continuant has dependents covered, please complete the following. (Please print)</b><br>Dependent Name (first, last, mi) _____<br>Birth Date:   Mo. _____ Day _____ Yr. _____<br>Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female<br>Social Security Number _____ - _____ - _____<br>Relationship to employee _____   Qualified Beneficiary <input type="checkbox"/><br><br>Dependent Name (first, last, mi) _____<br>Birth Date:   Mo. _____ Day _____ Yr. _____<br>Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female<br>Social Security Number _____ - _____ - _____<br>Relationship to employee _____   Qualified Beneficiary <input type="checkbox"/><br><br>Dependent Name (first, last, mi) _____<br>Birth Date:   Mo. _____ Day _____ Yr. _____<br>Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female<br>Social Security Number _____ - _____ - _____<br>Relationship to employee _____   Qualified Beneficiary <input type="checkbox"/> |   |
| <b>14) Qualifying Event that caused loss of coverage (check one)</b><br><b>Continuation of coverage for 30 months:</b><br><input type="checkbox"/> Employee's termination of employment (includes voluntary resignation, involuntary termination (except when due to gross misconduct), retirement, layoff, or leave of absence)<br><input type="checkbox"/> Employee's reduction in work hours (includes work stoppage or strike)<br><br><b>Continuation of coverage for 36 months:</b><br><input type="checkbox"/> Death of covered employee/retiree<br><input type="checkbox"/> Divorce/legal separation<br><input type="checkbox"/> Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage<br><input type="checkbox"/> Ineligibility of dependent child<br><input type="checkbox"/> Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy) United States Code |  |   |   |
| <b>Form completed by:</b> _____ <b>Date</b> _____  |  |   |   |
| <b>Name (print)</b> _____  |  | <b>Phone</b> _____ <b>Fax</b> _____   |   |

# **TRANSFERRING CURRENT COBRA/STATE CONTINUANTS TO CBIA SERVICE CORP. — COBRA/STATE CONTINUATION SERVICES**

Instructions for completing Continuant Takeover Form (on reverse side)  
(use one form per family unit)

This form is only needed if you have current COBRA/State Continuant to be transferred to  
CBIA Service Corp. — COBRA/State Continuation Services.

One form should be completed for each family unit and sent to:

**CBIA Service Corp. — COBRA/State Continuation Services,  
350 Church Street, Hartford, CT 06103-1126**

## **SECTION 1:**

Enter your company name.

## **SECTION 2:**

Enter your CBIA Case number.

## **SECTION 3:**

Check appropriate box to indicate whether  
Continuant is an employee or dependent. (Check  
one box only.)

## **SECTION 4:**

Enter the Continuant's complete nine-digit Social  
Security number.

## **SECTION 5:**

Enter Continuant's complete name (last, first,  
middle initial) and complete mailing address  
(street, city, state and ZIP Code.)

## **SECTION 6:**

Enter Continuant's home phone number, includ-  
ing area code, if available.

## **SECTION 7:**

Continuant's date of birth. (month, day, year)

## **SECTION 8:**

Check appropriate box to indicate the  
Continuant's gender (Male or Female)

## **SECTION 9:**

Check appropriate box to indicate marital status  
of Continuant.

## **SECTION 10:**

If the Continuant is a dependent of an employee  
or former employee, enter employee's complete  
name (last, first, middle initial), employee's nine-  
digit Social Security Number and Continuant's  
relationship to employee.

## **SECTION 11:**

Enter the month, day and year of the Qualifying  
Event.

## **SECTION 12:**

Enter the LAST DAY (month, day, year) of the  
Continuant's pre-COBRA/State Continuation of  
Coverage.

## **SECTION 13:**

Enter the FIRST PREMIUM DUE DATE for which  
CBIA Service Corporation — COBRA/State  
Continuation Services is to begin billing.

## **SECTION 14:**

Check appropriate box (check one box only) to  
indicate the type of Qualifying Event. "Employee's  
termination of employment" includes voluntary  
resignation, involuntary termination (except for  
termination due to gross misconduct), retirement,  
layoff, or leave of absence. Employee's reduction  
in hours includes work stoppage (strike)."

## **SECTION 15:**

Indicate coverage by checking the box of the  
appropriate plan code.

## **SECTION 16:**

Check appropriate box (Yes or No) to indicate  
whether at the time of the termination or reduc-  
tion in hours, the employee was eligible to  
receive Social Security income.

## **SECTION 17:**

Provide information if the Continuant has  
dependents covered, and indicate whether the  
individual is a Qualified Beneficiary and was cov-  
ered under the group health plan at the time of  
the original Qualifying Event or was born to or  
placed for adoption with a covered employee  
during the period of COBRA/State Continuation  
coverage.

# CBIA Service Corp. — COBRA/State Continuation Services

## Qualifying Event Form

**APPENDIX B**

**INSTRUCTIONS: Please print clearly**

- Fill out just one form per family unit (Qualified Beneficiary and Dependents)
- Please do not use this form to report existing COBRA/State continuants (use the Continuant Takeover Form).
- Please see back side of this form for further instructions.

**COMPLETE THIS FORM AND RETURN IT TO:**

CBIA Service Corp. — COBRA/State Continuation Services  
 350 Church Street  
 Hartford, CT 06103-1126  
 Fax: 860-278-0883

**NOTE:** Even if the Qualified Beneficiary tells you that he or she does not want continuation coverage, send a completed Qualifying Event Notification Form to CBIA Service Corp. within 14 days of the Qualifying Event.

|   |  |  |   |
|---|--|--|---|
| <b>1) From: (Company)</b> _____   |  | <b>2) CBIA Case Number</b> _____   |   |
| <b>3) Please be advised that the following has had a Qualifying Event.</b><br>(Check one box only) <input type="checkbox"/> (E)mployee <input type="checkbox"/> (D)ependent   |  | <b>4) Social Security Number of Qualified Beneficiary</b><br>_____ - _____ - _____   |   |
| <b>5a) Name of Qualified Beneficiary (last, first, mi) (Please print)</b><br>_____  |  |  |   |
| <b>5b) Street Address</b> _____   |  | <b>5c) City</b> _____  | <b>5d) State</b> _____  |
| <b>5e) ZIP Code</b> _____   |  |  |   |
| <b>6) Home Phone #</b><br>_____ - _____ - _____   |  | <b>7) Date of Birth of Qualified Beneficiary</b><br>____/____/____<br>M M D D Y Y Y Y  | <b>8) Gender</b><br><input type="checkbox"/> Male <input type="checkbox"/> Female |
| <b>9) Marital Status (check one box only.)</b><br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | <b>Continuation of coverage for 36 months:</b><br><input type="checkbox"/> Death of covered employee/retiree<br><input type="checkbox"/> Divorce/legal separation<br><input type="checkbox"/> Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage<br><input type="checkbox"/> Ineligibility of dependent child<br><input type="checkbox"/> Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy) United States Code |   |
| <b>10) If the Qualified Beneficiary listed in box #5 is not the employee, please complete the following; (Please print)</b><br>Employee Name (last, first, mi) _____<br>Employee SSN _____ - _____ - _____<br>Dependent's Relationship to Employee _____  |  |  |   |
| <b>11) Qualifying Event Date</b><br>____/____/____<br>M M D D Y Y Y Y   |  |  |   |
| <b>12) Last day of pre-COBRA/State Continuation Coverage (cannot be prior to Qualifying Event Date)</b><br>____/____/____<br>M M D D Y Y Y Y  |  | <b>15) If the Qualifying Event was for an employee and his/her spouse is covered, enter:</b><br>Spouse's full name: _____<br>Spouse's date of birth: ____/____/____<br>M M D D Y Y Y Y   |   |
| <b>13) Is this a second Qualifying Event for a dependent who is currently on COBRA/State Continuation?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   |  | <b>16) If the covered dependent(s) reside at a different address from the Qualified Beneficiary, please provide name and address:</b><br>(Attach a separate sheet if additional names need to be listed)<br>Name: _____<br>Street: _____<br>City: _____<br>State: _____ ZIP Code: _____  |   |
| <b>14) Qualifying Event that caused loss of coverage (check one)</b><br><b>Continuation of coverage for 30 months:</b><br><input type="checkbox"/> Employee's involuntary termination<br><input type="checkbox"/> Employee's resignation<br><input type="checkbox"/> Employee's retirement<br><input type="checkbox"/> Employee's reduction of hours<br><input type="checkbox"/> Employee's layoff<br><input type="checkbox"/> Employee begins leave of absence |  |  |   |
| <i>Continued in next column</i>   |  |  |   |
| <b>Form completed by:</b><br>Name (print) _____<br>Date _____<br>Phone _____ Fax _____  |  |  |   |

# QUALIFYING EVENT FORM CBIA SERVICE CORP. — COBRA/STATE C SERVICES

Instructions for completing Qualifying Event Form (on reverse side)

(use one form per family unit)

One form should be completed for each family unit and sent to:

CBIA Service Corp. — COBRA/State Continuation Services, 350 Church Street, Hartford, CT 06103-1126

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**SECTION 1:**

Enter your company name.

**SECTION 2:**

Enter your CBIA Case number.

**SECTION 3:**

Check appropriate box to indicate whether the Qualified Beneficiary is an employee or dependent. (Check one box only.)

**SECTION 4:**

Enter the Qualified Beneficiary's complete nine-digit Social Security number.

**SECTION 5:**

Enter the Qualified Beneficiary's complete name (last, first, middle initial) and complete mailing address (street, city, state and ZIP Code.)

**SECTION 6:**

Enter the Qualified Beneficiary's home phone number, including area code, if available.

**SECTION 7:**

Enter the Qualified Beneficiary's date of birth. (month, day, year)

**SECTION 8:**

Check appropriate box to indicate the Qualified Beneficiary's gender (Male or Female)

**SECTION 9:**

Check appropriate box to indicate marital status of Qualified Beneficiary.

**SECTION 10:**

If the Qualified Beneficiary is a dependent of an employee or former employee, enter employee's complete name (last, first, middle initial), employee's nine-digit Social Security Number and Qualified Beneficiary's relationship to employee.

**SECTION 11:**

Enter the month, day and year of the Qualifying Event.

**SECTION 12:**

Enter the LAST DAY (month, day, year) of the Qualified Beneficiary's pre-COBRA/State Continuation Coverage.

**SECTION 13:**

Enter only if a second qualifying event occurs for a dependent already on COBRA/State Continuation.

**SECTION 14:**

Check appropriate box (check one box only) to indicate the type of Qualifying Event.

**SECTION 15:**

Enter covered spouse information.

**SECTION 16:**

Provide information if the Qualified Beneficiary has dependents covered, and residing at a different address from Qualified Beneficiary.