

**QUALIFYING EVENT FORM**  
**CBIA Federal COBRA or State Continuation Services**  
**Serviced by Vimly Benefit Solutions Inc. (VBS)**

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

**CBIA Insurance Administration**

**350 Church Street, Hartford, CT 06103-1126 | Fax: 860-278-0883 | Email: HCService@cbia.com**

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**SECTION 1:**

Enter your company name.

**SECTION 2:**

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

**SECTION 3:**

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

**SECTION 4:**

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

**SECTION 5:**

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

**SECTION 6:**

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

**SECTION 7:**

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

**SECTION 8:**

Check appropriate box to indicate marital status of Qualified Beneficiary.

**SECTION 9:**

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 10:**

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

**SECTION 11:**

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

**SECTION 12:**

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

**SECTION 13:**

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

**SECTION 14:**

Enter covered spouse information.

**SECTION 15:**

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

PLEASE BE SURE TO COMPLETE ALL ITEMS AND TO SIGN AND DATE FORM. INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.

# CBIA Federal COBRA or 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 Federal COBRA or State Continuations (use the Continuant Takeover Form).
- Please see back side of this form for further instructions.

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

CBIA Insurance Administration  
 350 Church Street  
 Hartford, CT 06103-1126  
 Fax: 860.278.0883  
 Email: HCSERVICE@cbia.com

**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.

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

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