FlexibleBenefit ADMINISTRATORS
Ph: 800-437-FLEX or 757-340-4567
P.O.Box 2070 • Virginia Beach, VA 23450
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COBRA/Retiree Qualifying Event Notification Form

How to File

To be completed by Employer.

Print Form

Form can be submitted by (1) e-mail, (2) fax or (3) SFTP.

To submit by e-mail, to COBRA Print Form and sign. E-mail form to COBRAdivision@flex-admin.com
to RETIREE Print Form and sign. E-mail form to RETIREEdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by SFTP, post to your SFTP folder at https://securefile.flex-admin.com/

Qualifying Beneficiary

(Employee or dependent eligible for Continuation of Benefits)

Employers Name*: _____ *** Required Field**

Name: _____ (Print name) _____ (Social Security #)

_____ (Mailing Address)

_____ (City) _____ (State) _____ (Zip Code)

D.O.B. _____ Gender: _____ (Male or Female) Date of Hire: _____

Phone Number: _____ (Home Phone) _____ (Alternate Phone)

Employee's Information*

(if different from Qualifying Beneficiary)

Name: _____ (Print name)

Qualifying Event

Type

Please select one: _____ (Termination/Retirement/Reduced Hours/Divorce/Legal Separation/Employee's Death/Ineligible Dependent Employee's Medicare Entitlement/Loss of Coverage) _____ (Loss of coverage explanation)

Date

Original Qualifying Event Date (ie. last day of employment, date of death, etc.): _____

Retirement Date: _____

Loss of Coverage Date (effective date when insurance carrier terminated coverage): _____

Medicare Entitlement Date (date employee enrolled in medicare): _____

For loss of dependent status event only, loss of coverage date: _____

Department/Division

Benefit Plans & Coverage Level

☐ Retiree ☐ COBRA

	Benefits	Carrier & Plan Name	Initial Coverage Began	Coverage Level (member, spouse, mem&sp,mem&child,mem&children,mem&family)
☐	Medical			
☐	Dental			
☐	Vision			
☐	EAP			
☒	FSA			
☐	Other			

Last FSA Payroll deduction date:

If the primary Qualified Beneficiary was enrolled in the Flexible Spending Account, they must have a positive balance at the time of termination to continue participation.

For Takeovers Only

Is the Qualifying Beneficiary Currently Enrolled? (Yes or No) COBRA Premium Paid Through Date:

Dependent Information

Name (First, Last)	D.O.B.	Gender (Male or Female)	SS Number	Relationship (Spouse/Domestic Partner or Child)

Comments

