

Current Continuant Information

Discovery Benefits
COBRA

Employer Name (please print clearly and legibly)

1. Continuant Information

Continuant Status: Current Employee Former Employee Not Employee (spouse or dependent)

Continuant Name Continuant SSN - -

Address City State Zip

Date of Birth / / Phone - -

If Continuant named above is not a current or former employee, please provide the current or former employee name and SSN

Employee Name Employee SSN - -

2. Qualifying Event Date / /

3. Qualifying Events

- | | |
|---|--|
| <input type="checkbox"/> Voluntary Termination | <input type="checkbox"/> Death of Covered Employee |
| <input type="checkbox"/> Involuntary Termination | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Reduction in Hours (if reduction to zero hours, mark as involuntary termination) | <input type="checkbox"/> Legal Separation |
| <input type="checkbox"/> Medical Leave of Absence (FMLA <input type="checkbox"/> Yes <input type="checkbox"/> No) | <input type="checkbox"/> Child Losing Dependent Status |
| <input type="checkbox"/> Reservist called to active duty | <input type="checkbox"/> Employee Covered by Medicare |
| <input type="checkbox"/> Employer's Title 11 Bankruptcy (Retirees Only) | |

First Date of Active Coverage / / First Date of COBRA Coverage / /

Last Date of Active Coverage / / Last Date of COBRA Coverage / /

4. Current Benefits with Benefit Description (i.e. HMO, PPO, etc.)

| | | | | |
|--|---------------------------------|------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Health <input type="text"/> | <input type="checkbox"/> Single | <input type="checkbox"/> SPD | <input type="checkbox"/> Two Party | <input type="checkbox"/> Family |
| <input type="checkbox"/> Dental <input type="text"/> | <input type="checkbox"/> Single | <input type="checkbox"/> SPD | <input type="checkbox"/> Two Party | <input type="checkbox"/> Family |
| <input type="checkbox"/> Vision <input type="text"/> | <input type="checkbox"/> Single | <input type="checkbox"/> SPD | <input type="checkbox"/> Two Party | <input type="checkbox"/> Family |
| <input type="checkbox"/> Medical Spending Account | | | | |
| <input type="checkbox"/> Other <input type="text"/> | <input type="checkbox"/> Single | <input type="checkbox"/> SPD | <input type="checkbox"/> Two Party | <input type="checkbox"/> Family |

(e.g. Employee Assistant Program, cancer, accident, etc.)

COBRA Coverage Paid Through Date / /

5. Other Covered Family Members

Spouse Name

Address (if different from above) City State Zip

Date of Birth / / Spouse SSN - - Phone - -

Dependent Name (please attach another form for additional covered dependents)

Address (if different from above) City State Zip

Date of Birth / / Dependent SSN - - Phone - -

6. Assistance Eligible Individual Status Eligible Ineligible

Date AEI Notice Sent / / Start Date of AEI Subsidy / /

Has AEI Second Election Notice Been Sent? Yes No If Yes, Date Sent / /

Postmark Date of AEI Subsidy Waiver, if received / /

Postmark Date of AEI Subsidy Eligibility Attestation, if received / /

Completed by: _____ Phone # _____ Date _____
(please print clearly and legibly)