



P.O. Box 43653 Louisville, KY 40253-0653
(502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 www.bmsllc.net
COBRA Qualifying Event Notification Form

Employee Name: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Male: _____ Female: _____

Date of Hire: _____ Benefit Begin Date: _____ Qualifying Event Date: _____

Qualifying Event: (please check one)

<input type="checkbox"/>	Termination of a covered employee's employment (other than gross misconduct) Please indicate below whether termination was voluntary or involuntary. Voluntary Involuntary
<input type="checkbox"/>	A Reduction in a covered employee's hours of employment
<input type="checkbox"/>	The death of a covered employee, please list detailed information below
<input type="checkbox"/>	A divorce or legal separation from the covered employee, please list detailed information below
<input type="checkbox"/>	Ceasing to be a dependent child under the terms of the plan
<input type="checkbox"/>	The covered employee becomes eligible for Medicare, please list date eligible

Qualified Beneficiaries	Relationship to Employee	Date of Birth	Social Security Number

Coverage Currently Provided to Employee and/or Qualified Beneficiaries.
(Please note total cost of monthly premiums – do not include the additional 2% in the calculation. Also please list the detailed carrier information as outlined below.)

~~~~~	Health Insurance	Carrier Name & Plan Name	Monthly Premium
<input type="checkbox"/>	Employee Only		
<input type="checkbox"/>	Employee + Child(ren)		
<input type="checkbox"/>	Employee + Spouse		
<input type="checkbox"/>	Family		

~~~~~	Dental Insurance	Carrier Name & Plan Name	Monthly Premium
<input type="checkbox"/>	Employee Only		
<input type="checkbox"/>	Employee + Child(ren)		
<input type="checkbox"/>	Employee + Spouse		
<input type="checkbox"/>	Family		

_____ Other (Please note if: FSA, HRA, Vision, EAP, Etc.): _____

I certify that the beneficiary noted above has incurred a qualifying event and is now eligible for COBRA. I have notified the Plan Administrator (BMS LLC) within a maximum of 30-day period in order for the Administrator to proceed with notifying the qualified beneficiary within the required timeframe.

Employer's signature: _____ Date: _____

Company Name: _____

Please return this form to:
BMS LLC – Attn: COBRA Administrator Fax (502) 244-1162 or e-mail: cobra@bmsllc.net or
Enter Online at: www.MyTPAOnline.com

Accepted and Completed by BMS LLC Rep: _____ Date: _____