COBRA Ineligibility Form for Dependents

Use this form for documentation purposes only and save a copy in your employee's file.

Date:____________________________

Name:____ Social Security Number:__________________________

Re: COBRA coverage is not available for this member's dependent. The notification of ineligibility is outside of the 60-day window of when coverage would have been lost had the event been reported timely; or PEBA has terminated coverage due to a claims or audit.

Former spouse:

Name:____ Social Security Number:__________________________

Event

- ❑ Divorce.
- ❑ Legal separation.

Date of event: ____

Date of initial COBRA notification:____

- ❑ Includes 60-day notification language? If 60-day language not included, offer COBRA.

Date coverage would be terminated if event reported timely:____

Date benefits office notified:__________________________ By whom:____

- If benefits office notified within 60 days from date coverage would be terminated, offer COBRA.
- If event not reported within 60 days, do not offer COBRA. Place this form in insurance file for documentation.

Ineligible child:

Name:____ Social Security Number:__________________________

Event

Date of event: ____

- ❑ Terminated by PEBA due to no response to audit.

Date of initial COBRA notification:____

- ❑ Includes 60-day notification language? If 60-day language not included, offer COBRA.

Date coverage would be terminated if event reported timely:____

Date benefits office notified:__________________________ By whom:____

- If benefits office notified within 60 days from date coverage would be terminated, offer COBRA.
- If event not reported within 60 days, do not offer COBRA. Place this form in insurance file for documentation.

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Signature of benefits administrator