COBRA Ineligibility Form for Dependents

To: PEBA Insurance Benefits

Name _____

SSN _____ -_____ -_____

Date: _____

Re: COBRA not available for dependent—notification of ineligibility outside 60-day window of when coverage would have been lost had the event been reported timely or PEBA Insurance Benefits has terminated due to a claims or random audit.

Former Spouse

Name _____

SSN _____ -_____ -_____

Event Date of Event_____

☐ Divorce

☐ Legal Separation

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 not reported within 60 days, do not offer COBRA. Place this form in insurance file for documentation.

Ineligible Child

Name _____

SSN _____ -_____ -_____

Event Date of Event_____

☐ Terminated by PEBA Insurance Benefits 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 not reported within 60 days, do not offer COBRA. Place this form in insurance file for documentation.

Benefits Administrator Signature _____