COBRA Election Notice Form

Employer/Plan Information

Employer/Plan Sponsor Name

Plan Name

Employer/Plan Sponsor Address

Phone Number

Qualified Beneficiary Information

Qualified Beneficiary Name

Address

Date of Birth

SSN (last 4 digits)

Qualifying Event Information

Type of Qualifying Event

Date of Qualifying Event

COBRA Coverage Details

Start Date of COBRA Coverage

End Date of COBRA Coverage

Monthly Premium Amount

Payment Due Date

Instructions

Instructions to Qualified Beneficiary

Contact Information

Contact Name

Contact Phone

Contact Email

Notes