# COBRA Takeover Application

Company Name: ______________________ Tax ID: ______________________

Enrollee Name: ______________________ SSN: ______________________

Address: ______________________ City: ____________ State: ______ Zip Code: ______

Date of Birth: ______________ Sex: ❑ Male ❑ Female Date of Hire: ______________

Relationship to Former Employee: ❑ Self ❑ Spouse ❑ Child/Covered Dependent Coverage Start Date: ______________

Employee Name: ______________________ SSN: ______________________

Date SBMA begins Billing: ____________ Date of Qualifying Event: ____________ 1st Date of COBRA: ____________

## QUALIFYING EVENT INFORMATION

Please check only one option from the following categories:

18 Month Continuation

- ❑ Employee's Resignation
- ❑ Employee's Involuntary Termination
- ❑ Reduction in Hours
- ❑ Layoff
- ❑ Bankruptcy

29 Month Continuation (11-month extension)

- ❑ Disability Extension

36 Month Continuation

- ❑ Death of Covered Employee
- ❑ Divorce/Legal Separation
- ❑ Employee's Medicare Eligibility
- ❑ Loss of Dependent Eligibility

## COVERAGE INFORMATION

Provide the plan type and indicate which coverage(s) the above-named continuant has current coverage for (check the appropriate box below).

| Plan Type | Employee Only | Spouse Only | Child Only | Spouse + Children | Children Only | Employee + Spouse | Employee + Children | Family |
|---|---|---|---|---|---|---|---|---|
| | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

## DEPENDENT INFORMATION

Please provide dependent(s) mailing address on a separate sheet if different from continuant's mailing address.

| Name | Social Security Number | Date of Birth | Coverage Start Date | Relation to Employee |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please email completed applications to newgroup@sbmabenefits.com