UnitedHealthcare®
A UnitedHealth Group Company

COBRA/HIPAA Notification Form

UnitedHealthcare
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Telephone: 800-318-5311 **Fax:** 800-324-3195
Web site: www.uhcservices.com

Please complete this form initially for each of your current COBRA participants and anytime thereafter when an employee experiences a COBRA qualifying event. This form allows us to enter individuals into our COBRA administration system so we can manage their COBRA premium billing and communicate regularly with them. For us to properly process the individual, you must complete all fields in the form. Please return completed forms by e-mail to cobra@uhcservices.com, by fax to 800-324-3195 or via an online form at www.uhcservices.com. As an employer you must notify UHC Services within 30 days of a COBRA qualifying event.

Form Prepared by	Phone Number or Email Address of Preparer

1 Employer Information

Company Name	Location/ Division – if applicable

2 Employee/Qualified Beneficiary Information

Name		Social Security Number	Date of Birth
Address – Street, Apt. #		Phone Number	Gender ☐Male ☐Female
Address – City, State, Zip Code		Employee's Soc. Sec. # if a spouse/dependent is eligible for coverage separately	
Marital Status ☐Single ☐Married	Relationship ☐Employee ☐Spouse ☐Son ☐Daughter	If applicable, check the employee category that applies ☐ Salaried ☐Hourly ☐Union ☐Non-Union	

3 COBRA Qualifying Event Notice

Employee Qualifying Events	Spouse and/or Dependent Qualifying Events
☐Termination of Employment ☐Military Leave (USERRA) ☐Reduction of Hours ☐Retiree & COBRA Notice ☐Layoff ☐Disability - check if eligible participant was disabled at the time of the event ☐Already Enrolled* - check in addition to original qualifying event type	☐Death of Employee ☐Divorce or Legal Separation ☐Loss of Dependent Status ☐Employee Entitled to (covered by) Medicare ☐Already Enrolled* - check in addition to original qualifying event type

COBRA Qualifying Event/Retirement Date	Loss of Coverage Date – last day of active coverage	Notification Date – if already notified of rights*	Election Date – if coverage was already elected*	Paid Through Date – if payment has been made*	Next Billing Due – when next billing should start*

* Check and complete sections if this is a takeover and the participant has already elected to continue coverage.

4 Eligible Benefit Plans

Check the benefit plans the employee was enrolled in at time of the qualifying event. If this is a spouse or dependent that has experienced a qualifying event, check the benefit plans they are eligible to elect.

Type of Plan	Plan Name – if more than one plan	Type of Coverage – if "Other" please specify
☐ Health		☐EE Only or Single ☐EE + Spouse ☐EE + Child/ren ☐EE + One ☐Family ☐Other
☐ Dental		☐EE Only or Single ☐EE + Spouse ☐EE + Child/ren ☐EE + One ☐Family ☐Other
☐ Vision		☐EE Only or Single ☐EE + Spouse ☐EE + Child/ren ☐EE + One ☐Family ☐Other
☐ Other	Provide details	

Type of Plan	Annual Election Amount	Minus	Year to Date Deductions	Divided by	Months Remaining in Plan Year	Equals	Monthly Premium
☐ Medical Flex Spending Acct.	$		$				$

Type of Plan	Other than referrals – Provide details if needed	Type of Plan	Provide details if needed
☐ Employee Assist. Program		☐ Health Reimbursement Arrangements (HRA)	

Describe if there are any special premium arrangements specific to this person that would affect their coverage such as a severance package or subsidized rate.

5 Dependent Information *complete the following section if a spouse and/or dependent child(ren) were covered under a benefit plan*

List *spouse* and *dependents'* information <u>only</u> if covered under one or more benefit plans. Please also check "Handicapped" if handicapped child has no age limit for coverage under the plans he/she is enrolled in, or "Student Child" if full-time college student.

Spouse Name		Date of Birth – required	Social Security number – not required
Gender ☐ Male ☐ Female	Relationship to Employee ☐ Spouse		Coverage ☐ Health ☐ Dental ☐ Vision ☐ Other
Dependent #1 Name		Date of Birth – required	Social Security Number – not required
Gender ☐ Male ☐ Female	Relationship to Employee ☐ Son ☐ Daughter ☐ Student Child* ☐ Handicapped		Coverage ☐ Health ☐ Dental ☐ Vision ☐ Other
Dependent #2 Name		Date of Birth – required	Social Security Number – not required
Gender ☐ Male ☐ Female	Relationship to Employee ☐ Son ☐ Daughter ☐ Student Child* ☐ Handicapped		Coverage ☐ Health ☐ Dental ☐ Vision ☐ Other
Dependent #3 Name		Date of Birth – required	Social Security Number – not required
Gender ☐ Male ☐ Female	Relationship to Employee ☐ Son ☐ Daughter ☐ Student Child* ☐ Handicapped		Coverage ☐ Health ☐ Dental ☐ Vision ☐ Other
Dependent #4 Name		Date of Birth – required	Social Security Number – not required
Gender ☐ Male ☐ Female	Relationship to Employee ☐ Son ☐ Daughter ☐ Student Child* ☐ Handicapped		Coverage ☐ Health ☐ Dental ☐ Vision ☐ Other
Dependent #5 Name		Date of Birth – required	Social Security Number – not required
Gender ☐ Male ☐ Female	Relationship to Employee ☐ Son ☐ Daughter ☐ Student Child* ☐ Handicapped		Coverage ☐ Health ☐ Dental ☐ Vision ☐ Other

* If a student child or spouse resides at a different address, a separate COBRA notice must be sent. Provide the mailing address if applicable.

Spouse/Dependent Name	Address
Dependent Name	Address