EMPLOYER NOTICE OF QUALIFYING EVENT - TAKEOVER

For fastest processing, submit this form online via support request. You may also use one of the following methods:	Fax	Mail
	608-245-3623	BASIC, PO Box 14015 Madison, WI 53708-0015

EMPLOYER INFORMATION

Employer Name		Employer ID (12-digit)	
Division		Class	
Contact Name		Contact Phone	

PARTICIPANT INFORMATION

Employee First Name		MI		Last Name	
Participant First Name *(If different than employee)*		MI		Last Name	
SSN *(If Carrier Notices elected)*				Date of Birth	
Gender	☐ Female ☐ Male ☐ Other			Marital Status	☐ Married ☐ Single

Primary Address	Address 1					
	Address 2					
	City					
	State		ZIP		+4	

QUALIFYING EVENT INFORMATION

If the participant is a current continuation coverage enrollee, please provide:

Qualifying Event Date		Initial Enrollment Kit Sent Date	
Continuation Start Date		Premium Paid Through Date	

Qualifying Event Type *(Select one)*	☐ Involuntary termination of employment	☐ Voluntary termination of employment
	☐ Reduction in hours of employment	☐ Cessation of dependent status
	☐ Death of employee	☐ Start of employer bankruptcy proceeding
	☐ Divorce or legal separation from employee	☐ Retirement *(Retiree Billing only)*

SUBSIDY INFORMATION

Complete if employer is subsidizing all or a portion of continuation coverage premium as part of a severance agreement with the participant.

Adjusted Dollar Amount	
OR % Paid by Employer	
Severance End Date	

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COVERAGE INFORMATION

Indicate the level of coverage for each plan the participant is enrolled in currently:

Type	Name and Option of Benefit Plan e.g., PPO or HMO *(if applicable)*	Single	Single + Spouse	Single + 1 Child	Single + Children	Family
Health						
Dental						
Vision						
Other						

FSA	Annual Election Amount		FSA Plan Year End Date	
	Employee Contribution		Claims Paid To Date	

DEPENDENTS COVERED

First Name	Last Name	Relationship to Participant	Date of Birth	Gender	SSN *(If Carrier Notices elected)*

AUTHORIZATION

Name _____ Email _____

Signature _____ Date _____