

q3 business technology corp.
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Employer Notice to q3 of a HIPAA Certificate Request

Date of Notice: _____
From EMPLOYER: _____
Address: _____
Group #: _____

Participant Information

Name (First, Middle, Last): _____
Social Security Number: _____
Home Address: _____
City, State, Zip: _____
Date of Birth: _____

Participant(s) to whom this
information applies: _____

Date Waiting Period Began: _____
Date Coverage Began: _____
Date Coverage Ended: _____

On _____ (date), for the above participant(s):

- Coverage ended
- COBRA Continuation coverage ended
- COBRA Qualifying event occurred
- Certificate was requested

Please send a HIPAA Certificate of Coverage within 14 days of the receipt of this notice to the name and address above.

Signature: _____ Title: _____

Printed Name: _____