q3 business technology corp. ***www.q3online.com***
P. O. Box 15952 ***Phone 260.492.9979 877.251.8324***
Fort Wayne, IN 46885 ***Fax 260.492.9989***

Employer Notice to q3 of a Qualifying Event for COBRA Continuation Coverage

Date of Notice: _____

From EMPLOYER: _____

Address: _____

Group #: _____

Qualified Beneficiary Information

Name (First, Middle, Last): _____

Social Security Number: _____

Home Address: _____

City, State, Zip: _____

Date of Birth: _____

Marital Status: ❑ Single ❑ Married

No. of Dependent Children: _____

Date of Hire: _____

On _____(date), the above qualified beneficiary incurred the following "qualifying event" which caused the qualified beneficiary to lose group health coverage for purposes of COBRA continuation coverage:

Qualifying Event for Employee: ❑ Voluntary ❑ Involuntary

- ❑ Termination of employment
- ❑ Reduction in hours of employment due to

(reason:_____)

Qualifying Event for Dependent(s):

- ❑ Death of employee
- ❑ Employee's Medicare entitlement
- ❑ Start of bankruptcy proceeding
- ❑ Divorce or legal separation from employee
- ❑ Cessation of dependent status

Health Coverage Information

Level of Coverage: ❑ Single ❑ Family
❑ Employee + 1 ❑ Employee + 2 or more
❑ Employee + Spouse ❑ Employee + Child(ren)

Dependent(s) on plan, if any:

Spouse: Name _____

Child(ren): Name(s) _____

Coverage under the plan will terminate on _____ (date). Please send the aforementioned person (and his or her spouse and dependent child(ren), if any) the appropriate election notices and forms for COBRA continuation coverage within 14 days of the receipt of this notice, as required under COBRA.

Signature: _____ Title:_____

Printed Name: _____