QUALIFIED EVENT NOTICE FORM

DATE: ____________________________________

EMPLOYEE INFORMATION

EMPLOYEE: ____

ADDRESS: ____

____

TELEPHONE: ____

SOCIAL SECURITY #: ____

QUALIFYING EVENT: ____

SPOUSE & DEPENDENTS: ____

____

HIRE DATE: ____

INSURANCE INFORMATION

COVERAGE TYPE: INDIVIDUAL _____ FAMILY _____ INDIVIDUAL + 1 _____

PREMIUMS: MEDICAL __________ DENTAL __________ TOTAL __________

2% INCLUDED: YES __________ NO __________

WAITING PERIOD FOR HEALTH INSURANCE: _____________