



COBRA-QUALIFIED BENEFICIARY COVERAGE CONTINUATION NOTIFICATION REQUEST

Instructions: Complete this form only for coverage continuance not related to employment (e.g. dependents no longer eligible for coverage). Complete the *TERMINATION AND COBRA COVERAGE CONTINUATION REQUEST* only for events related to employment. Forms must be received at the League office by the 21st of the month. If received after the 21st, this information will appear on a subsequent premium statement. COBRA notifications are mailed to qualified beneficiaries every Friday.

Company Name	Authorized Signature	Date
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Please Print or Type

Employee Last Name	Employee First Name	M.I.	Social Security Number		
Street Address	City	State	Zip Code	Hire Date	Date of Birth

Please Print or Type

Qualified Beneficiary Last Name	Qualified Beneficiary First Name	M.I.	Social Security Number		
Street Address	City	State	Zip Code	Date of Birth	

Reason for Termination of Coverage

<input checked="" type="checkbox"/> Please check one.
<input type="checkbox"/> Death of Employee on _____. <input type="checkbox"/> Divorce from Employee on _____. <input type="checkbox"/> Dependent child attained age limitation or ceases dependent status under policy on _____. <input type="checkbox"/> Medicare eligibility of employee or parent on _____. <input type="checkbox"/> Retirement (Employee over age 65) on _____. <input type="checkbox"/> Bankruptcy under Chapter 11 filed on _____.

Student Information — Please Print or Type

Is the Qualified Beneficiary a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, Name of the Institution: _____ Expected Completion Date of Studies: _____

Note: If the qualifying event indicated above will result in a change of the current contract type for which the Employee is enrolled, please attach to this form an Enrollment/Change form to process the conversion.

Please return this form to:

Bankers Cooperative Group, Inc.
COBRA Administration Unit
411 North Avenue East
Cranford, New Jersey 07016

COBRA Coverage Terms for this form

36 Months

- * Death of Employee
- * Dependent Age Attainment
- * Employee Medicare Eligibility
- * Legal Separation or Divorce
- * Retirement (Employee over 65)
- * Employer Bankruptcy under Chapter 11