



MONGOOSE®

COBRA QUALIFYING EVENT SUBMISSION



Please mail, fax, or email to:

AMERIFLEX
700 East Gate Drive, Suite 510
Mount Laurel, NJ 08054
Attn: COBRA Department
E-mail: COBRA@flex125.com
Phone: 888-868-3539
Fax: 609.257.0136

Instructions:

1. This form must be submitted within 30 days of the qualifying event to ensure timely notification of COBRA rights.
2. Complete one (1) form per Qualified Beneficiary. (Please do not use this form for any existing COBRA participants)
3. Please confirm that this event has been accurately submitted and entered. Report any discrepancies immediately.

NOTE: This form should still be submitted even if the plan member informs you that COBRA continuation is not wanted.

Employer Information

Company Name: _____ Date: _____

Your Name: _____ Email: _____

Qualified Beneficiary (QB) Information

QB Name: _____
Salutation First Name MI Last Name

SSN: _____ Individual ID: _____ Email: _____

Address: _____

City: _____ State: _____ Zip+4: _____ Phone: _____

Gender: M F DOB: _____ Tobacco Use: Y N Employee Type: _____ Payroll Type: _____

Qualifying Event (QE) Information

Category: Employee Dependent Event Type Description (i.e. term or divorce): _____

QE Date: _____ Original Enrollment Date: _____

If the QB is NOT the Employee, please complete this section

Employee: _____ SSN: _____ Relation: Spouse Parent

Is this a 2nd Qualifying Event of a current QB? Y N If YES, date of first qualifying event: _____

Please check all plans the QB was enrolled in prior to the Qualifying Event

Medical EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____

Dental EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____

Vision EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____

EAP EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____

Pharmacy EE EE+SP EE+CH EE+CHILDREN FAMILY EE+1 EE+2 Plan Name: _____

FLEX Monthly Contribution: _____ Other: _____

Dependent Information if QB is currently enrolled with Dependent Coverage

Spouse: _____ SSN: _____ Gender: M F DOB: _____ Enrolled: _____

Child: _____ SSN: _____ Gender: M F DOB: _____ Enrolled: _____

Child: _____ SSN: _____ Gender: M F DOB: _____ Enrolled: _____

Child: _____ SSN: _____ Gender: M F DOB: _____ Enrolled: _____

Address if different from QB: _____

American Recovery & Reinvestment Act of 2009 Information

Is the QB (and Spouse/Dependents) an Assistance Eligible Individual (AEI)? YES NO