**COBRA Compliance Checklist**

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| Beneficiary Name: Marital Status:Address: |
| Nature of Event: 18 months = Termination Reduced Hours  29 months = Social Security Disability 36 months = Death of Employee Divorce Legal Separation  Child Ceasing to be a dependent Medicare Entitlement  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if event was termination, was it voluntary or involuntary – circle one) |
| Date of Qualifying Event:  |
| Date Employee Reported Event (divorce, loss of dep. status, death, Medicare): / /  |
| Signature of Representative Completing this Form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| “☑”if done | **Description of Activity/ Date of Completion** |
| initials: | Prepare appropriate COBRA letter and election form with premium figures (attach copies) Note: **Employee has 60 days to notify Employer of loss of coverage due to death, Medicare eligibility, loss of dependent status, and divorce.\*** |
| Initials: | If Employee reported Q.E. more then 60 days after its occurrence, send the “COBRA Not Available” Letter (Document E).\* |
| initials: | **Within 14 days of loss of coverage**, mail COBRA letter, election form to all persons/qualified beneficiaries effected by loss of coverage. Date Completed: / /  |
| initials: | Completed Election Form must be returned no more than **60 days** from date of loss of coverage or date notification was sent, whichever is *later.* Form due / /🖛***Enter date completed form is received:*** **/ /** (attach copy of form)**Note: Q.B.s who decline coverage, can change their mind within the 60 day window.** **After the 60 day window expires, and coverage is not elected, your duty ends. \*** |
| initials: | If Employee reported Qualifying Event more then 60 days after its occurrence, send the "COBRA Not Available" Letter (Document E).\* |
| initials: | Payment for coverage is due 45 days after receipt of election form on: / / 🖛 **First Payment of $\_\_\_\_\_\_for \_\_\_\_\_\_ months of coverage received on: / /**(log in and deposit payment, attach copy of check)\* |
| initials: | Payment Records: X out the # of the month to denote payment for that month. I-----------------Termination/reduction in hours -------------I I------------Disability ext.--------------I I--Divorce, death, etc.--I{  1   2   3   4   5   6   7   8   9  10 11 12 13 14 15 16 17 18 } ( 19 20 21 22 23 24 25 26 27 28 29 ) { 30 31 32 33 34 35 36 } |
|  |  |
| initials: | Date of event causing extension or termination: \_\_\_\_ /\_\_\_\_ / \_\_\_\_ (attach correspondence)• Terminate (early): [   ] Failure to pay \*  [   ] Medicare Eligible    [   ] Obtained other coverage• Extend:  [   ] Second Qualifying Event   [   ] Social Security Disabled • Terminate: [   ] 18 months expired   [   ] 36 months expired   [   ] 29 months expired   |

 Notes: (use back of this page to record any other notes)

**\**NOTE: Due to the impact of COVID-19, if an individual experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Checklist may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***