



EMPLOYER NOTIFICATION TO COX HEALTHPLANS TO CONTINUE MEMBER'S COVERAGE

Date notification was given for continuance: _____

Note: Medical insurance may be continued subject to COBRA guidelines and State Continuation laws.

To be Completed by Employer:

Employer Name: _____

Employer Group Number: _____

Present number of full and/or part-time employees: _____

Qualifying event has occurred for: _____ Employee _____ Dependent

Was qualifying event due to involuntary employment termination? _____

Date of qualifying event: _____ Reason for qualifying event: _____

Monthly COBRA premium:	\$		Date premium received:	
Amount paid:	\$		Check number:	

Name and dates of birth of persons to be continued:

Name	Date of Birth	ID Number-or-SS#
Employee:		
Spouse:		
Child:		
Child:		
Child:		
Child:		
Child:		

Authorized employer signature

Date

Disclaimer:

This application should be used to notify Cox HealthPlans only and not the notifications to be used in notifying a Qualified Beneficiary.