Employer Documentation Form: Qualifying Event Verification

A: ☐ Termination of Employment	
Termination of Coverage Effective Date:	Termination of Employment Date:
B: ☐ Status Change/Reduction of Hours	
Termination of Coverage Effective Date:	Employee Eligible for Health Coverage? ❑ Yes ❑ No
C: ☐ Dependent Turning Age 26	
Termination of Coverage Effective Date:	Name of Dependent:
D: ☐ Dependent Child Disenrolled from Group Plan during Open Enrollment	
Date of Group Plan Open Enrollment:	Termination of Coverage Effective Date:
Name(s) of Dependent(s) Disenrolled from Group Plan:	

Member/Employer Information		
Member Name:		
All Dependents Losing Coverage:		
Employer Name:		
Employer Contact Name:	Employer Contact Title:	
Employer Contact Phone #:	Employer Contact Email:	
Employer Contact Signature (electronic signature not valid):	Date:	**OFFICE USE ONLY:** QMXGR# _____

*Additional documentation may be required.

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