WOOD COUNTY EMPLOYEE HEALTH PLAN
COBRA PERSONNEL ACTION REPORT

EMPLOYEE SECTION:

Department ______________________________ Group Number ____________ Date ____________

Last Name _________________________________ First _______________________________ MI _________

Address: ____
Street/PO Box City State Zip

Social Security # ____/____/____ Date of Birth ____/____/____ Phone No. _____________ Sex: M/F

Check the Current Insurance Plan and Level in Force for **only** those types of coverage that you **currently** carry.

Current Insurance Plan	Current Level In Force Single	Family**	*Initial Effective Date
_____ Health Plan	______	______	________
_____ Prescription Plan	______	______	________
_____ Vision Plan	______	______	________
_____ Dental Plan	______	______	________

*__Date subscriber first became effective on the WC Employees Benefit Programs. **Complete back if family coverage in force.__

Any combination of current benefits or a reduction of benefits (Family to Single) may be selected when enrolling.

Complete the following by inserting only **one** number for Qualifying Event:

Qualifying Event: _____ (Use Number Below) **Last Date of Active Pay Status** __________ (Required)

		Maximum Months of Coverage
(1)	Employee terminated or laid off for reasons other than gross misconduct as follows: (Please check applicable reason) ____ Resigned ____ Laid Off ____ Retired ____ Discharged ___ Other Other Reason: ___________________________ (for involuntary terminations an attestation must be attached)	18 months
(2)	Employee's hours have been reduced resulting in loss of coverage.	18 months
(3)	Employee's divorce or legally separated. If yes, please complete PQB section below.	36 months
(4)	Limiting Age - No longer considered a "dependent". If yes, complete PQB Section below.	36 months
(5)	Employee died. If yes, please complete PQB Section below.	36 months
(6)	Employee elected Medicare.	
(7)	Employee on Active Duty Military Leave.	24 months

How Employer Notified? (circle one) Mail, Telephone, In Person By Whom? _____________________

Date Employee notified Employer of Qualifying Event _____/____/_____

* *

PQB SECTION (PRINCIPAL QUALIFYING BENEFICIARY): (This section is for dropping a single dependent or spouse.)

PQB is (circle one): Spouse/Dependent DOB ____/____/____ SS # ____/____/____ Sex: M/F Phone # ________

PQB Name: Last ____________________________________ First _______________________________ MI ____

Address ____
Street City Zip

Please list the **initial effective date** (when participant first became enrolled) for each type of coverage:

Health (date) ___/___/___ Prescription (date) ___/___/___ Vision (date) ___/___/___ Dental (date) ___/___/___

Is this dependent covered under a National Medical Support Notice through Child Support Enforcement? ☐**Yes** ☐**No**

If subscriber is terminating coverage please use the back of this form to list multiple current dependents also being terminated.

FAMILY MEMBER SECTION: (Please complete if multiple family members are being terminated.)

Last Name: _____ First: _____ MI: _____ Date of Birth: _____

Social Security # _____ Relationship to Subscriber: _____ Spouse _____ Dependent Sex: M/F

Fill in initial effective date (when it first became effective) for each type of coverage for this dependent.

Health ____/____/____ Prescription ____/____/____ Vision ____/____/____ Dental ____/____/____
Effective Date Effective Date Effective Date Effective Date

****

Last Name: _____ First: _____ MI: _____ Date of Birth: _____

Social Security # _____ Relationship to Subscriber: _____ Spouse _____ Dependent Sex: M/F

Fill in initial effective date (when it first became effective) for each type of coverage for this dependent.

Health ____/____/____ Prescription ____/____/____ Vision ____/____/____ Dental ____/____/____
Effective Date Effective Date Effective Date Effective Date

****

Last Name: _____ First: _____ MI: _____ Date of Birth: _____

Social Security # _____ Relationship to Subscriber: _____ Spouse _____ Dependent Sec: M/F

Fill in initial effective date (when it first became effective) for each type of coverage for this dependent.

Health ____/____/____ Prescription ____/____/____ Vision ____/____/____ Dental ____/____/____
Effective Date Effective Date Effective Date Effective Date

****

Last Name: _____ First: _____ MI: _____ Date of Birth _____

Social Security # _____ Relationship to Subscriber: _____ Spouse _____ Dependent Sex: M/F

Fill in initial effective date (when it first became effective) for each type of coverage for this dependent.

Health ____/____/____ Prescription ____/____/____ Vision ____/____/____ Dental ____/____/____
Effective Date Effective Date Effective Date Effective Date

****

Last Name: _____ First: _____ MI: _____ Date of Birth: _____

Social Security # _____ Relationship to Subscriber: _____ Spouse _____ Dependent Sex: M/F

Fill in initial effective date (when it first became effective) for each type of coverage for this dependent.

Health ____/____/____ Prescription ____/____/____ Vision ____/____/____ Dental ____/____/____
Effective Date Effective Date Effective Date Effective Date

Refer to the Plan Document for further information.