WOOD COUNTY EMPLOYEE HEALTH PLAN
COBRA PERSONNEL ACTION REPORT

EMPLOYEE SECTION: Department___________________________

Last Name ___________________________________ First _________________________________ MI _________

Address: ____
Street/PO Box City State Zip

Social Security # __________________ Date of Birth _________________ Phone No. ______________________

Sex: M/F Employee Hire Date _______________________ Employee Term Date_______________________

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	Current Level In Force: 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

Date Employee notified Employer of Qualifying Event ____________________

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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

PQB Name: Last _______________________________________ First _________________________________ MI ____

Address ____
Street City Zip

☐ Check if address is same as the Employee's Address.

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

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

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

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

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

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

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

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

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

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

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.