



COBRA QUALIFYING EVENT FORM

Timber Products Manufacturers Trust
 951 East Third Avenue, Spokane, WA 99202
 (509) 535-4646 phone (509) 533-1947 fax COBRA@tpmrs.com

EMPLOYEE INFORMATION

Employer Name:	Group Number:
Employee Name:	SSN:
Employee Current Address:	
City:	State:
Date of Hire:	
Original Date of Coverage:	
Phone:	
Zip:	

ENROLLMENT INFORMATION

Relationship to Employee	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender	
						Male	Female
Self						<input type="checkbox"/>	<input type="checkbox"/>
Spouse						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

QUALIFYING EVENT TYPE

<input type="checkbox"/> Involuntary Termination	<input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Ineligible Dependent	<input type="checkbox"/> Medicare Entitlement
<input type="checkbox"/> Gross Misconduct Termination	<input type="checkbox"/> Death of Employee	<input type="checkbox"/> Employee Disability	<input type="checkbox"/> Lay Off or Leave of Absence
<input type="checkbox"/> Voluntary Termination	<input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Employee Retired	<input type="checkbox"/> Leave of Absence- Military

Date of Qualifying Event: _____ Coverage Termination Date: Is _____

there a Severance Package for COBRA? No Yes (explain) _____

COVERAGE

Coverage Type	Yes	No	*Plan Type:	**Census:	Rate:
Medical Coverage					
Dental Coverage					
Vision Coverage					

*Plan type description (PPO, Buy-up, Core, Relevant Plan Number, Etc.) _____

**Census Type

1 Employee Only	3 Child Only	6 Employee & Child	9 Employee, Spouse & Children
1 Over Age Dependent Only	4 Children Only	7 Employee & Children	10 Spouse & Child
2 Spouse, Ex-spouse, widow only	5 Employee & Spouse	8 Employee, Spouse & Child	11 Spouse & Children

Does a dependent have a different mailing address? Yes No If yes, complete the following:

Dependent's Name (Last, First MI) _____

Dependent mailing address: _____