Qualifying Event Notice ~ FlexBank Submission Form

The plan administrator must furnish an election notice to each qualified beneficiary (covered employee, covered spouse, and any covered dependent child) who loses plan coverage in connection with the qualifying event. As part of your ongoing COBRA services, FlexBank will send the election notice for you. It is the employer's responsibility to inform FlexBank who to send the notice to. **The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event.**

There are two ways to get this information to FlexBank:
1) Enter the information in our only employer portal, please contact your FlexBank account manager if you are not familiar with our online employer portal

2) Complete this form and return it to email Compliance@FlexBank.net ~ fax 937.299.5609.

Employer Information	
Employer Name	Date
Contact Name	Contact Email
Qualified Beneficiary (QB) Information	
Employee Name	Employee SSN
QB Name	QB SSN
Employee Address	Division/Department (if applicable)
Email Address	Phone Number
Date of Birth	Male ☐ or Female ☐
Is the QB the: Employee Spouse Other	
Qualifying Event (QE) Information	
Category ☐ Employee ☐ Dependent	Event Description: ☐Termination ☐ Retirement ☐ Medicare Entitlement ☐Death ☐Becoming an Ineligible Dependent ☐Reduced Hours ☐Divorce/Separation ☐Leave of Absence (family/medical) ☐ Loss of Coverage ☐USERRA ☐ Termination with Severance
Qualifying Event Date	Original Enrollment Date
Is this a second QE of a current QB? No ☐ Yes ☐ If yes, date of first QE	

Plan Information - The QB is enrolled in the following:						
Medical	Plan Name	☐ EE	☐ EE+SP	☐ EE+CH	☐ EE+Children	☐ Family
HRA	Plan Name	☐ EE	☐ EE+SP	☐ EE+CH	☐ EE+Children	☐ Family
Dental	Plan Name	☐ EE	☐ EE+SP	☐ EE+CH	☐ EE+Children	☐ Family
Vision	Plan Name	☐ EE	☐ EE+SP	☐ EE+CH	☐ EE+Children	☐ Family
EAP	Plan Name	☐ EE	☐ EE+SP	☐ EE+CH	☐ EE+Children	☐ Family
FSA	Monthly Contribution		Date of Last Payroll Withholding			
HSA	Date of Last Payroll Withholding					

Dependent Information If QB is currently enrolled with dependent coverage, complete below:					
Relationship & Name	SSN	Date of Birth	Gender	Enrolled in which of the above plans?	Address (if different than employee)
Spouse Name			☐ Female ☐ Male		
Child Name			☐ Female ☐ Male		
Child Name			☐ Female ☐ Male		
Child Name			☐ Female ☐ Male		
Child Name			☐ Female ☐ Male		