# **WEB-TPA** P. O. Box 1987, Grapevine, Texas 76099-1987 800.477.8957 • Fax 469.417.1979



If a member, spouse or dependent experiences:1) divorce, 2) legal separation, 3) child loses dependent status, or 4) member medicare or medicaid entitlement, this form must be completed by the member and/or spouse and sent to WEB-TPA within 60 days of the qualifying event for the qualified beneficiaries to be eligible for continuation of coverage under COBRA.

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	mber/Spouse Notice		ent		
Plan Catastrophic Major M	/ledical Benefit Plan (CHIP) 🛛 🔲 Voluntary S	Supplemental Medical and Custodial	Care Benefit Plan (SMP		
Qualifying Event			Care Denent Flan (Sim		
Guanrying Event					
Divorce	Date of Divorce	Last Date of Coverage	Last Date of Coverage		
Legal Separation	Date of Legal Separation	Last Date of Coverage	Last Date of Coverage		
Child Losing Dependent Status	Reason (i.e. reached maximum age on plan)	Last Date of Coverage	Last Date of Coverage		
Member Medicare o	or Medicaid Entitlement (CHIP only)	Last Date of Coverage			
Family Member(s)	Losing Coverage				
Spouse Name:					
Date of Birth:	Social Security #:				
Address:	City	State	Zip		
Dependent Name:					
Date of Birth:	Social Security #:	Telephone #:			
Address:	City	State	Zip		
Dependent Name:					
Date of Birth:	Social Security #:	Telephone #:			
	City				

Member Name:					
Date of Birth:	Employee #:		Telephone #:		
Address:		City	State	Zip	
			Date:		

Please see back of this form for instructions on how and when to complete.

# Instructions for Completing This Form

This form must be completed and sent to WEB-TPA within 60 days of the Qualifying Event.

# Please complete this form IF:

- ♦ You;
- your spouse; or
- one of your Dependents

experience one of the following four qualifying events:

- Divorce (attach first and last page of divorce decree)
- Legal Separation (attach first and last page of separation agreement)
- Child Losing Dependent Status
- Member Medicare or Medicaid Entitlement (CHIP only)

### **Qualifying Event**

Please check the box that applies for your situation. Provide the date of the event, the reason your dependent child is no longer an eligible dependent (if applicable) and the last date of coverage.

#### Family Member(s) Losing Coverage

Please provide the names and addresses of all family members who are losing coverage due to the qualifying event indicated above. This may include the spouse and one or more children.

#### Member Data

Please provide the name, address and other information requested for the member.

#### Plan

Please check the plan(s) in which the family members listed above are currently enrolled.

## Completed By

The individual completing and submitting this form should sign and date the form.

Please mail the completed form directly to WEB-TPA at P. O. Box 1987, Grapevine, Texas 76099-1987 or Fax to 469.417.1979.