

For groups electing to participate in HealthPass COBRA/NYSC Administration.

Group Name: \_\_\_\_\_ Group Number (if available): \_\_\_\_\_

Group Effective Date/Renewal Date (MM/DD/YYYY): \_\_\_\_\_

Employee Name: \_\_\_\_\_

COBRA Enrollee Name (if COBRA enrollee is a dependent): \_\_\_\_\_

COBRA enrollee's relationship to employee (choose one):

- Self Spouse Child Other

Original Qualifying Event (check one):

- Employee termination Death of covered employee
Employee entitlement to Medicare Divorce/ Legal Separation
Reduction in hours Loss of dependent child status

Qualifying Event Date (MM/DD/YYYY): \_\_\_\_\_ Original COBRA Start Date (MM/DD/YYYY): \_\_\_\_\_

Attach additional required documents:

- Completed Enrollment/Change Form
Proof of Prior Employment (new groups only)
(ie: Last NYS-45 where employee appeared before termination)

Payment Information (new groups only):

Amount of COBRA payment included with binder payment: \_\_\_\_\_

Please note: Once COBRA is active, monthly payment coupons will be sent to the COBRA member. After the initial payment, all subsequent payments should be mailed to the HealthPass COBRA Lockbox to ensure timely processing.

bswift - HealthPass
PO BOX 860620
MINNEAPOLIS MN 55486-0620

HealthPass/bswift INTERNAL USE ONLY

Ticket Number
Billing notified: Yes No
Funds transferred to COBRA: Yes No