

Mid American Group
P.O. Box 482
Westmont, IL 60559
630-789-9508
630-789-9421 FAX

- Original Form. If you fax, do not mail copy.
- Revision to form previously sent.

COBRA/HIPAA Transmittal Form

(This form is to be used when an individual has a qualifying event)

Employer Name	Telephone #	Fax #	Plan #	Div. #
Name of Insured Employee (Last, First, Middle Int.)			Telephone #	
Address		City	State	Zip
Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female		

List the name of the Health Plan in which coverage was lost:

Health Plan _____ Type _____ Status _____
(HMO,PPO,POS) (single, single+1, family, etc.)
First Day Health Coverage (with this carrier) ____/____/____

Dental Plan _____ Type _____ Status _____
(HMO,PPO) (single, single+1, family etc.)
First Day Dental Coverage Began (with this carrier) ____/____/____

Vision Plan _____ Status _____
First Day Dental Coverage Began (with this carrier) ____/____/____

HIPAA Related Information	
<p>Proof of 18 months of prior coverage must be provided to the terminating employee. If those 18 months were not completed with the above-provided information, prior carrier information will be required below. The dates (month, day, year) must be provided for each plan.</p> <p>For Dependents: The information reported on the plans above will be used for each covered dependent. However, if the dates are different for one or more dependents, you must provide the dependent names and dates on a separate piece of paper. Please indicate below on this form the number of pages attached.</p>	
Prior Health Plan _____ Type _____ Status _____ (HMO,PPO,POS) (single, single+1, family, etc.) First Day Health Coverage (with this carrier) ____/____/____	
Prior Dental Plan _____ Type _____ Status _____ (HMO,PPO,POS) (single, single+1, family, etc.) First Day Dental Coverage (with this carrier) ____/____/____	

What is the date the qualifying event took place? Month _____ Day _____ Year _____
(i.e. the actual day of termination)

What is the date the coverage was lost? Month _____ Day _____ Year _____

Reason for the qualifying event: (Check the correct event)

- | | |
|---|---|
| <input type="checkbox"/> TERMINATION OF EMPLOYMENT (for any reason) | <input type="checkbox"/> DIVORCE OR LEGAL SEPARATION |
| <input type="checkbox"/> REDUCTION OF WORK HOURS (no longer eligible for benefits) | <input type="checkbox"/> MEDICARE ENTITLEMENT (Dependents may continue coverage) |
| <input type="checkbox"/> DEPENDENT REACHING LIMITING AGE (Please list the dependent(s) losing coverage below) | <input type="checkbox"/> DEATH OF THE EMPLOYEE |
| | <input type="checkbox"/> DEPENDENT NO LONGER FULL-TIME STUDENT (Please list the dependent(s) losing coverage below) |

Give the following information for each dependent losing coverage:
 (If address of covered dependent is different from qualified beneficiary please provide address on a separate sheet.)

Name (last, first, middle initial)	Relationship	Date of Birth	Sex M or F	Soc. Sec. Number	Full Time Student? Yes or No

In order to comply with COBRA/HIPAA legislation YOU MUST FAX OR MAIL THIS COMPLETED FORM WITHIN 30 DAYS of qualifying event to the above address.

 Signature of Employer

 Date

 # of pages including this page

I agree that all of the above information is correct. I understand that Mid American Group is not responsible for inaccuracies or misinformation contained in this form or any resulting COBRA/HIPAA violations as a result of such errors.
 (Forms must be signed or will be returned)