

# COBRA

## Employer Notice Memo or Send a copy of Form 11

_____		_____		
Name of Employee		Social Security Number		
_____		_____		_____
Number and Street or P. O. Box		City	State	ZIP

The above identified employee of \_\_\_\_\_  
is covered in the SEHIP and under the provisions of COBRA we hereby provide SEIB notice  
that the following qualifying event has occurred relative to the employee.

1. \_\_\_\_ Termination of employment for any reason other than gross misconduct.  
Date of termination: \_\_\_\_\_
2. \_\_\_\_ Reduction in hours of employment. This includes leave without pay.  
Date of reduction: \_\_\_\_\_
3. \_\_\_\_ Death of the employee.  
Date of death: \_\_\_\_\_
4. \_\_\_\_ Medicare eligibility of the employee.  
Date of eligibility: \_\_\_\_\_

Date: \_\_\_\_\_ Employer: \_\_\_\_\_