C O B R A

Employer Notice Memo
Or
Send a copy of Form 11

_____ _____
Name of Employee Social Security Number

_____ _____
Address City State Zip

The above identified employee of_____
is covered in the State Employees' Health Insurance Plan and, under the provisions of COBRA, we hereby provide the State Employees' Insurance Board 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:_____

STATE EMPLOYEES' INSURANCE BOARD
PO BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-263-8541