Employer Notice of Qualifying Event – California COBRA

*Required Field

For employers with 2 to 19 eligible employees on at least 50% of its working days during the preceding calendar year.

Employee: Please complete and return to us each time a covered employee has a qualifying event which causes them to be eligible for continuation coverage under the California Continuation Benefits Replacement Act.

Return completed form within 30 days of the last day worked or qualifying event to:

Address: Sun Life Financial
Sun Life Administrative Office
P.O. Box 981624
El Paso, TX 79998-1624
Fax: 888.208.2323

Check the coverages you wish to continue: *

- ☐ Dental
- ☐ Vision
- ☐ Critical Illness
- ☐ Gap
- ☐ Cancer
- ☐ Accident
- ☐ Employee Assistance Program

Employer Name * ______________________ Policy no. * ______________

Employer address * ______________________________________

Name of Covered Employee * ______________________ Certificate no. ______________

Date of Qualifying Event* ______________________ Date Coverage Terminated * ______________

Date qualified individual was notified of California COBRA rights* ______________________

Qualifying Events *(Please check the appropriate box.)* *

- ☐ Termination of employment (except gross misconduct) or reduction in hours of the covered employee's employment
- ☐ Divorce or legal separation of the covered employee from the covered employee's spouse
- ☐ Loss of dependent status by a dependent enrolled in the group benefit plan
- ☐ For a covered dependent only, the covered employee's entitlement to Medicare
- ☐ Death of covered employee
- ☐ Occurrence of a second qualifying event (explain) ______________________________________

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Employer's signature * ______________________________ Date * ______________

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