

Ceridian COBRA Continuation Services

COBRA QUALIFYING EVENT

CS-61317/04

PLEASE CHECK ORIGINAL NOTICE If FAXED, do not mail copy.
 ONE BOX ⇒ REVISION . . . to a form that was previously sent.

1a) From (Company)
Lake-Sumter Medical Society

1b) Division or Region Code 1c) Company ID or Unit Code
 (If applicable, refer to the Client Rate Report for the one character to two characters required [alpha and/or numeric] to complete 1b and 1c above.)

2) Ceridian COBRA Services Account Number
#23702626601

3) Please be advised that the following has had a Qualifying Event. (check one)
 (E)mployee (D)ependent

4) Social Security Number of Qualified Beneficiary
 - -

5a) Qualified Beneficiary's Name (last, first, mi)

5b) Street (include apartment number)

5c) City 5d) State 5e) Zip Code

6) Home Phone # of Qualified Beneficiary (include Area Code) - -
 7) Employee # (if applicable)

8) Date of Birth of Qualified Beneficiary
 M M D D Y Y Y Y
 9) Gender (check one)
 (M)ale
 (F)emale

10) If the Qualified Beneficiary listed in box #5a is not the employee, enter the following:
 Employee Name (last, first, mi) _____
 Employee SSN - -
 Dependent's Relationship to Employee _____

11) Qualifying Event Date

 M M D D Y Y Y Y

12) Last day of pre-COBRA Coverage (cannot be prior to Qualifying Event Date)

 M M D D Y Y Y Y

13) Is this a second Qualifying Event for a dependent who is currently on COBRA? (N)o (Y)es

14) If employee, does he/she have a health care FSA?
 (N)o (Y)es (If yes, MONTHLY contribution \$ _____)

15) Refer to your Client Rate Report and enter the current Carrier Option, Option Code and Plan Code for each coverage in effect on the Qualifying Event Date:

	Carrier Code	Option Code	Plan Code*
Med or HMO	_____	_____	_____
Dental	_____	_____	_____
Vision	_____	_____	_____
Hearing	_____	_____	_____
Prescription	_____	_____	_____
Other	_____	_____	_____

*Select from the following current Plan Code Coverages. Ceridian administers only Plan Code coverage options that are permitted by your plan or carrier:
 1 = Individual 3 = Family 14 = Individual+Child
 2 = Individual + 1 9 = Individual + Spouse 15 = Individual + Children

16) COBRA Qualifying Event that caused loss of coverage (check one)
 Continuation of coverage for 18 months:

- Employee's retirement (Code 6)
- Employee's reduction in hours (Code 2)
- Employee's resignation (Code 1)
- Employee's layoff (Code 8)
- Employee's involuntary termination (Code 9)
- Employee's begins leave of absence (Code 9)

Continuation of coverage for 36 months:

- Divorce/legal separation (Code 4)
- Death of covered employee/retiree (Code 3)
- Ineligibility of dependent child (Code 6)
- Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings by sponsoring employer under title 11 (bankruptcy) United States Code (Code 7)
- Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of coverage (Code 5)

17) Spouse/Dependent Information. Each name should include last, first and middle initial.

Name of Spouse _____
 Social Security Number - -
 Date of Birth
 M M D D Y Y Y Y
 Gender Male Female
 Address (if different from participant) _____

Name of Dependent _____
 Social Security Number - -
 Date of Birth
 M M D D Y Y Y Y
 Gender Male Female
 Address (if different from participant) _____

Name of Dependent _____
 Social Security Number - -
 Date of Birth
 M M D D Y Y Y Y
 Gender Male Female
 Address (if different from participant) _____

Name of Dependent _____
 Social Security Number - -
 Date of Birth
 M M D D Y Y Y Y
 Gender Male Female
 Address (if different from participant) _____

Please see Addendum if additional names need to be listed in this section

Prepared By _____
 Name: (PRINT) _____
 Date:
 M M D D Y Y Y Y
 Telephone # - -
 Fax # - -