REQUEST FOR COBRA LETTER

Please fill out & return to:
ADMINASSISTANT@DUKEINSURANCEBROKERAGE.COM
Or fax to: (413).547.8239

Part I (EMPLOYEE INFORMATION)

Employer Name: _____

Employee Name: _____

Spouse Name (if covered under plan)**:** _____

Employee Address (Street #): _____

(City, State, Zip): _____

PART II (TERMINATION)

Last Day of Employment: _____

Effective Date of Plan Termination: _____

Reason for Termination: _____

Was Employee Terminated for Reasons of Gross Misconduct (please circle)**?** **YES** **NO**

PART III (COVERAGE)

Health Insurance Carrier: _____

Tier (please circle)**:** **Employee** ✔ **EE+ SP** ✔ **EE+Child(ren)** ✔ **Family** ✔

Dental Insurance Carrier: _____

Tier (please circle)**:** **Employee** ✔ **EE+ SP** ✔ **EE+Child(ren)** ✔ **Family** ✔

Vision Insurance Carrier: _____

Tier (please circle)**:** **Employee** ✔ **EE+ SP** ✔ **EE+Child(ren)** ✔ **Family** ✔

Requested By: _____ **Date:**_____

FOR OFFICE USE ONLY
Date Received: _____ Initials: _____
Date Prepared: _____ Initials _____
Date Proofed: _____ Initials: _____