Lucas County Employee Benefits
COBRA Notification Form

Current Date _____/_____/_____ Employee ID_____
Department _____ Department Code _____

Last Name _____ First Name _____ M.I. _____

Address _____
Street City State Zip Code
Social Security Number _____ Date of Birth ____/____/____
Telephone Number ( ) _____-_____ Sex ☐ Male ☐ Female

Current Insurance Plan(s): ☒ all that apply
☐ Anthem Non-Deductible Plan ☐ Anthem Deductible Plan
☐ Blue View Vision
☐ Delta Dental
Current Coverage : ☐ Single ☐ Family

Qualifying Event: _____ (Use Number Below) **Date of Event** _____/_____/_____
18 months:
(1) Employee terminated or laid off for reasons other than gross misconduct as follows:
(Please X applicable reason)
☐ Resigned ☐ Discharged ☐ Retired ☐ Laid Off
☐ Disability Retirement ☐ Strike ☐ Other_____
(2) Employee's hours have been reduced resulting in loss of coverage.
36 months: *If you answer **yes** to questions **(3)** through **(6)**, please complete the **PQB Section** below.*
(3) Employee divorced or legally separated.
(4) Dependent child ceasing to be a dependent. Reason_____ .
(5) Employee died.
(6) Employee elected Medicare.

Date Employee notified Employer of Qualifying Event _____/_____/_____
How was Employer notified? _____ By Whom? _____
mail, telephone, in person, etc.

PQB Section (Principal Qualifying Beneficiary)
PQB is (X one): ☐ Employee ☐ Spouse ☐ Dependent
(If Employee is PQB, do not complete the following section.
If spouse or dependent is PQB, please complete the PQB Information below).

PQB Information
Last Name _____ First Name _____ M. I. _____
Address _____
Street City State Zip Code
Social Security Number _____ Date of Birth_____/_____/_____
Telephone Number ( ) _____/_____ Sex ☐ Male ☐ Female

Please return the completed form to the Lucas County Employee Benefits Department, One Government Center, Suite 440, Toledo, Ohio 43604 Revised 1/21/2025