COBRA/NYSC Takeover Form

For groups electing to participate in HealthPass COBRA/NYSC Administration.

Group Name:_____ Group Number (if available):_____

Group Effective Date/Renewal Date (MM/DD/YYYY):_____

Employee Name:_____

COBRA Enrollee Name (if COBRA enrollee is a dependent):_____

COBRA enrollee's relationship to employee (choose one):

❒ Self ❒ Spouse ❒ Child ❒ Other_____

Original Qualifying Event (check one):

❒ Employee termination
❒ Employee entitlement to Medicare
❒ Reduction in hours
❒ Death of covered employee
❒ Divorce/ Legal Separation
❒ Loss of dependent child status

Qualifying Event Date (MM/DD/YYYY): _____ Original COBRA Start Date (MM/DD/YYYY): _____

Attach additional required documents:

❒ Completed Enrollment/Change Form
❒ Proof of Prior Employment (new groups only)
(ie: Last NYS-45 where employee appeared before termination)

Payment Information (new groups only):

Amount of COBRA payment included with binder payment:_____

Please note: Once COBRA is active, monthly payment coupons will be sent to the COBRA member. After the initial payment, all subsequent payments should be mailed to the HealthPass COBRA Lockbox to ensure timely processing.

HealthPass COBRA
PO Box 2008
Omaha, NE 68103-2008

HealthPass/bswift INTERNAL USE ONLY

Ticket Number _____
Billing notified: ❒ Yes ❒ No
Funds transferred to COBRA: ❒ Yes ❒ No