C O B R A

Employer Notice Memo
Or
Send a copy of Form 11

_____ _____
Name of Employee Social Security Number

_____ _____
Number and Street or P. O. Box City State ZIP

The above identified employee of_____
is covered in the SEHIP and under the provisions of COBRA we hereby provide SEIB notice that the following qualifying event has occurred relative to the employee.

1. ____ Termination of employment for any reason other than gross misconduct.
Date of termination: _____

2. ____ Reduction in hours of employment. This includes leave without pay.
Date of reduction: _____

3. ____ Death of the employee.
Date of death: _____

4. ____ Medicare eligibility of the employee.
Date of eligibility: _____

Date: _____Employer:_____

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-517-9728