STARK COUNTY

ADDITIONAL INFORMATION REQUIRED BY COBRA

(*Formerly GIP-7*)

Please complete ALL fields and send to the Human Resources' Benefits Department when a dependent is being terminated from an employee's health insurance coverage:

Who is being terminated?

☐ **Spouse** ☐ **Dependent Child**

Employee:

Last Name _____**First Name** _____**M.I.**_____

Street Address _____

City _____**State** _____ **Zip Code** _____

Date of Birth_____ **Social Security Number** _____

Spouse or Dependent:

Last Name _____**First Name** _____**M.I.**_____

Street Address _____

City _____**State** _____ **Zip Code** _____

Date of Birth_____ **Social Security Number** _____

Reason no longer eligible as employee's dependent:

Effective date of change: _____

Employee Signature: _____

Department:

_____

Revised 9/2015