STATE CONTINUATION QUALIFYING EVENT REPORT

To be completed by the Employer.

Please complete this form when an event occurs that causes a loss of group health coverage for a covered employee, spouse or dependent. This may entitle them to state continuation coverage under ORS 743.610.

Submit this form to:

Email: commercialchanges@samhealth.org or Fax: 541-768-9937

Mail: Samaritan Health Plans, Sales Department, PO Box M, Corvallis, OR 97339

EMPLOYER INFORMATION			
Group name:		Group ID number:	
Association name, if applicable:			
EMPLOYEE INFORMATION			
Last name:	First name:	Middle initial:	
Date of birth (mm/dd/yyyy):	Social Security Number:		
Address:			
Phone:	Marital status:	Member ID number:	
Plan Name:	Vision: ❑ Yes ❑ None	Alternative Care Option: ❑$15 ❑$25 ❑ None	
State continuation coverage: ❑ Yes ❑ No	If yes, state continuation coverage ends (mm/dd/yyyy):		

DESCRIPTION OF EVENT

Qualifying event: ❑ Termination of employment ❑ Reduction in hours ❑ Divorce
❑ Legal separation ❑ Death of subscriber ❑ Medicare eligibility ❑ Loss of dependent status
❑ Termination of membership in the group covered by the group insurance policy (i.e. union membership)

Date of qualifying event (mm/dd/yyyy):	Last day of coverage (mm/dd/yyyy):

COVERED DEPENDENT(S)

Name	*Date of birth (mm/dd/yyyy)*	*Relationship to employee*	*Plan name*	*Vision Y/N*	*Alt Care Y/N*

ALTERNATE ADDRESSES

If any covered dependent(s) live at a different address than the Employee, please provide that information below, if known.

Name	*Address*

SAMARITAN HEALTH PLANS USE ONLY	
Date received:	Notes: