PAYCHEX®

COBRA Conversion Report

Company Name ______________________________
Office/Client Number ______________________________
Federal ID Number __ __ __ __ __ __ __ __ __

This form is used only if you have employees already enrolled or pending enrollment in COBRA. It is your responsibility to complete this report prior to the Paychex effective date.

Qualified Participant or Dependent	Social Security Number	Date of Birth	Event Code*	State or Fed**	Qualifying Event Date	COBRA Effective Date (loss of coverage date)	Plan Type	Date Original Insurance Became Effective	Name of Insurance Carrier	Circle the applicable coverage level that should be offered to the employee and/or dependent(s)	Date Paychex Will Take Over COBRA
Name: Address: City: State: Zip: Relationship: Gender:						__/__/__ ❑ Pending ❑ Enrolled	Medical Dental Vision Prescription			Employee Employee + Children Employee + Spouse Employee + Child Family Other____________ Monthly Premium: $	
Name: Address: City: State: Zip: Relationship: Gender:						__/__/__ ❑ Pending ❑ Enrolled	Medical Dental Vision Prescription			Employee Employee + Children Employee + Spouse Employee + Child Family Other____________ Monthly Premium: $	
Name: Address: City: State: Zip: Relationship: Gender:						__/__/__ ❑ Pending ❑ Enrolled	Medical Dental Vision Prescription			Employee Employee + Children Employee + Spouse Employee + Child Family Other____________ Monthly Premium: $	
Name: Address: City: State: Zip: Relationship: Gender:						__/__/__ ❑ Pending ❑ Enrolled	Medical Dental Vision Prescription			Employee Employee + Children Employee + Spouse Employee + Child Family Other____________ Monthly Premium: $	

***Event Codes**

1) Termination 2) Retirement 3) Death 4) Reduced hours (changed from full-time to part-time status) 5) Ineligible dependent 6) Divorce/Legal separation
7) Other: ______________________________

**If you fall under State or Federal Continuation guidelines or did at the time of the individual's continuation of coverage, indicate by putting either an "S" or "F" in the box.

Client Contact: ______________________________ Date: ____/____/____ Telephone Number: ______________________________

E-mail: APC_COBRA@paychex.com Fax: 585-249-4290 Mail to: Paychex/COBRA Department, 150 Sawgrass Drive, Rochester, NY 14620