STATE OF NEW MEXICO
COBRA Notification Form

Client Name: State of New Mexico
State Agency/LPB Code: _____
Group Rep Name: _____
Group Rep Telephone #: _____
Date Submitted: _____

Email To: SONM@easitpa.com

please complete one form per employee

SS #	Name	Complete Address City, State & Zip Code	Date of Birth

Cobra Eff. Date	*Level	**Event Code	Plan #	Date of Hire	Orig Eff. Date of Coverage	Term Date of Coverage

***Level:** E=Employee, S=Employee plus spouse, F=Family
C=Employee plus child/children

Plan Number: #1=BCBS PPO, #2=PRES HMO, #3=BCBS HMO, #4=Delta Dental, #5=Davis Vision

****Event Code:** 1=Reduction in Work Hours 2=Termination of Employment
3=Death of Employee 4=Voluntary Termination
5=Legal Separation or Divorce 6=Social Security Disability
7= Retirement

Reason For Termination:

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