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/childre

Plan Number : #1 BCBS Gold PPO, #2 BCBS Silver HDHP, #3 BCBS Gold HMO, #4 BCBS Platinum HMO.
#5 Pres. Gold PPO, #6 Pres. Silver HDHP, #7 Pres. Gold HMO, #8 Pres. Platinum HMO
#9 UNMR Gold PPO, #10 UNMR Silver HDHP, #11 UNMR Gold HMO, #12 UNMR Platinum HMO,
#13 Delta Dental Basic, #14 Delta Dental Buy Up, #15 Metlife Basic, #16 Metlife Buy Up,
#17 Vision Basic, #18 Vision Buy Up

****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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