

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@casitpa.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 **Plan Number:** #1=BCBS PPO, #2=PRES HMO, #3=BCBS HMO,
 C=Employee plus child/children #4=Delta Dental, #5=Metlife Dental, #6=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:
