**NEEDS TO BE ON COMPANY LETTERHEAD**

**CERTIFICATE OF CREDITABLE COVERAGE**

|  |  |  |
| --- | --- | --- |
| **DATE OF THIS CERTIFICATE** |  | |
| ***PLAN ADMINISTRATOR INFORMATION*** | | |
| **NAME OF PREVIOUS EMPLOYER** |  | |
| **ADDRESS, CITY, STATE ZIP** |  | |
| **HR CONTACT NAME** |  | |
| **HR CONTACT PHONE** |  | |
| **NAME OF EMPLOYEE** |  | |
| **CERTIFICATE APPLIES TO THE FOLLOWING INDIVIDUALS** | | |
| **EMPLOYEE** |  | |
| **SPOUSE** |  | |
| **CHILD** |  | |
| **CHILD** |  | |
| **INSURANCE CARRIER** |  | |
| **GROUP ID #** |  | |
| **MEMBER ID #** |  | |
| **DATE COVERAGE BEGAN** |  | |
| **DATE COVERAGE ENDED** |  | |
| **The reason for this loss of coverage is due to (indicate one):**  *Termination, Retirement, Non-payment of Cobra, Death of Employee, Disability, other-indicate* | |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Human Resources/Benefits Manager**