QUALIFIED BENEFICIARY
NOTICE TO PLAN ADMINISTRATOR OF QUALIFYING EVENT

INSTRUCTION SHEET (E13)

NOTE: The Plan Administrator should make the *Qualified Beneficiary Notice to Plan Administrator of Qualifying Event* form readily available to covered employees, plan participants, qualified beneficiaries, and any representative acting on behalf of a qualified beneficiary. The form must be provided free of charge.

RECIPIENTS: A qualified beneficiary, plan participant, or any representative acting on behalf of a qualified beneficiary may request and submit a completed form to the Plan Administrator.

DEADLINE DATE: Upon request, the Plan Administrator should provide this form as soon as possible. The covered employee or qualified beneficiary has 60 days from the date of the qualifying event or the date of loss of coverage under the Plan, whichever is later, to return this completed form to the Plan Administrator. Notice by one individual satisfies the notice requirements for all other qualified beneficiaries with respect to the qualifying event.

FORM COMPLETION:

Page 2: The Plan Administrator should fill in his/her contact information at the bottom of page 2. The rest of page 2 is to be completed by the covered employee or qualified beneficiary and returned to the Plan Administrator.

NOTE: The Plan's SPD should be updated to indicate that covered employees and qualified beneficiaries must submit this completed form to the Plan Administrator upon the occurrence of certain qualifying events (e.g., divorce, legal separation, dependent child's loss of dependent status, Social Security disability determination), and second qualifying events.

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****PLEASE READ CAREFULLY** As a participant in the organization's group health plan as either a covered employee, spouse, or dependent child, you have a responsibility to submit this completed form (page 2) to the Plan Administrator upon the occurrence of certain qualifying events as described below. Notification by a qualified beneficiary satisfies the notification requirement for all qualified beneficiaries with respect to the qualifying event. Failure to provide notice to the Plan Administrator may affect you and/or your family members' right to elect or extend COBRA continuation coverage.**

Notification of Qualifying Events

A covered employee, spouse, or dependent in the organization's group health plan is responsible for notifying the Plan Administrator if any of the following qualifying events occur:

- Employee's legal separation;
- Employee's divorce; or
- A dependent child ceases to be a covered dependent under the Plan.

This completed form must be submitted to the Plan Administrator within **60** days from the later of the date of the qualifying event or the date of loss of coverage under the Plan.

COBRA Extension Due to Disability

A qualified beneficiary and any covered family members who are currently receiving 18 months of COBRA continuation coverage may be eligible to extend the maximum period of coverage to 29 months if the qualified beneficiary is determined to be disabled by the Social Security Administration (SSA). The SSA's disability determination must be made before the 60th day of COBRA coverage and before the end of the 18-month period. The qualified beneficiary or a covered family member must notify the Plan Administrator of the SSA's disability determination by submitting this completed form within **60** days of such determination.

A qualified beneficiary must notify the Plan Administrator if the SSA subsequently determines that the individual is no longer disabled within **30** days after the date of the SSA's final determination.

Second Qualifying Event

Covered spouses and dependents who are currently receiving 18 or 29 months of COBRA continuation may be able to extend the period of coverage up to a maximum of 36 months if a second qualifying event occurs. Examples of second qualifying events include a covered employee's legal separation or divorce or a dependent child ceasing to be a covered dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. The employee's entitlement to Medicare is therefore not a second qualifying event unless (ignoring the first qualifying event) it would result in a loss of coverage under the Plan. You must notify the Plan Administrator of a second qualifying event within **60** days by submitting this completed form.

Birth or Adoption of a Child

If during a qualified beneficiary's period of continuation coverage there is a birth of a child or a child is placed in the qualified beneficiary's home for adoption, the child will be covered under the Plan immediately if the qualified beneficiary submits either this completed form or the appropriate health insurance form to the Plan Administrator within **30** days of the birth or adoption.

QUALIFIED BENEFICIARY NOTICE
TO PLAN ADMINISTRATOR OF QUALIFYING EVENT

Date of Notice:	Name of Group Health Plan:

List each individual who is a participant in the organization's group:

☐ medical insurance plan ☐ dental insurance plan ☐ Other _____
(please specify)

Employee Name:

Name of Spouse or Former Spouse (if applicable):

Names of Dependent Children (if applicable):

Qualifying event or second qualifying event that has occurred: Date of qualifying event: _____

☐ Divorce of employee and spouse
☐ Legal separation of employee and spouse
☐ Dependent ceasing to qualify for coverage under the Plan
☐ Qualified beneficiary is disabled per the Social Security Administration

I would like to add the following individual to the group health plan(s) due to the following:

Name: _____

☐ Birth of my child Date of birth: _____
☐ A child has been placed in my home for adoption Date of adoption: _____

Current Address of Employee: _____

Current Address of Spouse (if different): _____

Current Address of Dependent Child/Children (if different): _____

Name(s) of Dependent Child/Children Residing at the Different Address Listed Above: _____

_____

Contact the Plan Administrator if you have questions or assistance is needed in filling out this form. This completed form should be submitted to the Plan Administrator at the address below within the deadline dates indicated.

Name of Plan Administrator: _____ Telephone #: _____

Address: _____

Signature of Employee or Qualified Beneficiary Completing Form:	Date:
Print Name:	Relationship to Individual(s) listed above: