#### Qualifying Event Notification Form

*(To notify* ***{Employer Name}*** *of a qualifying event or Social Security Disability)*

**Attention Employee and/or Spouse and Dependent:**

This form is to be completed by a covered employee, spouse or dependent to report certain events to **{Employer Name}** as required under provisions of the federal Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA). Failure to complete and submit this form in a timely manner will result in a loss of health insurance continuation rights that are available under COBRA. Should you have any questions as to this form’s purpose or how to complete the form, please contact **{Employer Name}**

##### Instructions

Please complete the information requested and submit this form to **{Employer Name}.** The notice must be received by the Plan Administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date that the qualified beneficiary would lose coverage on account of the qualifying event.

|  |
| --- |
| Name of Company: **{Employer Name}** |
| Name of Covered Employee: |
| Name of Reportee: |
| Relationship to Employee: |

**Please Check One:**

**🗌 Death- as second event Date of event:\_\_\_\_\_\_\_\_\_\_** (attached copy of death certificate)

**🗌 Divorce: Is it a second event? Yes /No Date of event:\_\_\_\_\_\_\_\_\_\_** (attached signed copy of

divorce decree)

**🗌 Legal Separation: Is it a second event? Yes/No Date of event:\_\_\_\_\_\_\_\_\_\_\_\_** (attached signed

copy legal separation)

**🗌 Child Ceasing to be a dependent: Is it a second event? Yes/No Date of event:\_\_\_\_\_\_\_\_\_\_\_**

**🗌 Social Security Disability Date of Social Security disability:\_\_\_\_\_\_\_\_\_\_**

(enclose Social Security Disability determination which needs to be submitted within 60 days from

the date the determination is made and within the original 18 months or continuation coverage)

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

signature of reportee Date

**Current Mailing Address of Qualified Beneficiary:**

**Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mail or hand deliver completed form to {Employer Name}, {Employer address}. Thank you.**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***