Please submit this form to your employer

COBRA - Notice of Qualifying Event Form

Instructions and Notice Procedures

Within this form, "you" and "your" refer to the employee covered under their employer's Healthcare Management Administrators (HMA) group health plan (the "Plan"), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice. This form, including the notice procedures listed in this form, are part of the Plan's COBRA initial notice. **For more information** about this form, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's Summary Plan Description (SPD) and the other provisions of the Plan's COBRA initial notice. You may obtain copies of these documents from your employer. **Use this form when** any of the following qualifying events occurs and, due to the qualifying event, you're requesting COBRA coverage: **1)** A spouse covered under the Plan becomes divorced or legally separated from the covered employee, **2)** The covered employee reduced or eliminated his or her spouse's Plan coverage in anticipation of their divorce or legal separation, and the anticipated divorce or legal separation has subsequently occurred, **or 3)** A child covered under the Plan ceases to be a dependent under the terms of the Plan.

Submission Deadline: You must provide this Notice of Qualifying Event (your "Notice") within 60 calendar days of the latest of (1) the qualifying event and (2) the date the covered spouse or dependent child would lose coverage under Plan terms as a result of the qualifying event, if the event occurred while the qualified beneficiary was covered under the Plan.

Submission Options and Submission Requirements
Oral/verbal notice, including notice by phone, isn't acceptable. You must **provide your Notice to your employer in writing**. Contact your employer to determine their accepted **Submission Options**. If you mail your Notice, it must be postmarked no later than the **Submission Deadline**. If you hand-deliver your Notice to your employer, they must receive it no later than **Submission Deadline**. The Plan's contact information is included in the most recent SPD; you may request a copy of the SPD from your employer.

If you're notifying your employer of a **divorce or legal separation**, you must **include a copy of the decree of divorce or legal separation with your Notice**. If your coverage is reduced or eliminated, then later a divorce or legal separation occurs, and you are notifying your employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide your Notice within 60 days of the divorce or legal separation. In addition, you must provide evidence satisfactory to your employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation. Note: Even if divorce terms require paying for an ex-spouse's health insurance, it doesn't mean they can stay on the Plan.

If you provide an incomplete Notice, the Plan will consider your Notice as timely only if *all* of the following conditions are met:

- You provide your Notice **to your employer** through one of their accepted **Submission Options** by the **Submission Deadline**;
- From your Notice, your employer is able to: 1) Determine it relates to the Plan, and 2) Identify the covered employee, the qualified beneficiary(ies), the qualifying event, and the date the qualifying event occurred;
- If applicable, your Notice is supplemented in writing with any additional information/material needed to meet Plan requirements within 15 business days of request for more information (or, if later, by the **Submission Deadline**).

If your Notice meets all **Submission Requirements**, the Plan will treat your Notice as having been provided on the date the Plan received all required information/material, but will still consider your Notice as timely. Otherwise, the Plan will consider your Notice to be incomplete and won't offer COBRA coverage.

Additional Evidence of Date of Qualifying Event May Be Required: If your Notice is regarding a child's loss of dependent status, you must provide written evidence of the qualifying event if your employer requests it. This will help your employer determine if your Notice was timely and if you are entitled to COBRA coverage. If you don't provide satisfactory evidence within 15 business days of request from your employer, the Plan may terminate the child's COBRA coverage (retroactively, if applicable). **In that event, your employer will require repayment to the Plan of all benefits paid after the termination date.**

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Employee Information

Provide information on the employee covered by the Plan. This person is also known as the Subscriber.

Full Name _____ **Employee ID Number**[?] _____

Mailing Address _____

Group Name or Plan Name _____ **Group ID Number**[?] _____

[?] *This information can be located on your insurance ID card. "Employee ID" is also called "Member ID".*

Qualifying Event Information

Select the **one** applicable qualifying event (A or B) and provide the required information.

○ **Event A:** Employee and Spouse: O **Divorced** *OR* O **Legally Separated** on (mm/dd/yyyy): _____

Spouse's Name _____ **Mailing Address** _____ ☐ *Same as employee*

Is the decree of divorce or legal separation enclosed with this notice? ○ Yes ○ No

If the spouse's coverage was eliminated/reduced and later a divorce or legal separation occurred, is evidence the spouse's Plan coverage was eliminated/reduced in anticipation of the divorce or legal/separation enclosed with this notice? ○ Yes ○ No ○ N/A

○ **Event B:** Employee's Child Ceased to Be an Eligible Dependent Under the Plan on (mm/dd/yyyy): _____

Child's Name _____ **Mailing Address** _____ ☐ *Same as employee*

Why did the child cease to be an eligible dependent? (pick **one** reason): ○ Child Attained Age ○ Other (explain below)

Explanation (If "Other"): _____

Attachments

Reminder: You **must** attach/include a copy of all required documentation. Otherwise, your submission may be delayed or ultimately rejected if you don't adequately respond to additional information requests within the required deadlines.

Signature

_____ _____ _____

Printed Name (First and Last) **Phone Number** **Relationship to Employee (If you are the Employee, put "Self")**

_____ ☐ *Same as employee*

Mailing Address

_____ _____

Signature **Date**

By signing this Form you attest that 1) You are the employee referenced herein, a qualified beneficiary of the employee (such as a spouse, a former spouse, or a current/former dependent child), or are otherwise legally authorized to represent them; 2) The information listed herein is correct to the best of your knowledge; 3) You understand and acknowledge all stipulations listed herein.