COBRA - Notice of Second Qualifying Event Form

Instructions and Notice Procedures

Within this form, "you" and "your" refer to the employee covered under their employer's 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. Within this form, "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator. This form, including the notice procedures listed in this form, are part of the Plan's COBRA initial notice and COBRA election notice for 18-month qualifying events. 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 and election notice (for 18-month qualifying events). You may obtain copies of these documents from your employer. **Use this form when** any of the following second qualifying events occurs and, due to the qualifying event, you're requesting an extension of COBRA coverage: 1) A spouse who is receiving COBRA coverage becomes divorced or legally separated from the covered employee, 2) A child covered under the Plan ceases to be a dependent under the terms of the Plan, or 3) The covered employee dies while one or more qualified beneficiaries are receiving COBRA coverage.

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

Submission Requirements
Oral/verbal notice, including notice by phone, isn't acceptable. **You must provide your Notice to us in writing** through one of the **Submission Options** herein. If you mail your Notice, it must be postmarked no later than the **Submission Deadline**. If you're notifying us of a **divorce or legal separation**, you **must include a copy of the decree of divorce or legal separation** with your Notice. 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, we'll consider your Notice as timely only if *all* of the following conditions are met:

- You provide your Notice to us through one of the **Submission Options** by the **Submission Deadline**;
- From your Notice, we are able to: 1) Determine it relates to the Plan, and 2) Identify the covered employee, the qualified beneficiaries, the qualifying event, and the date the qualifying event occurred;
- If applicable, you supplement your Notice 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 all of these conditions are met, we'll 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, we'll consider your Notice to be incomplete and we won't extend your 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 we request it. This will help us determine if your Notice was timely and if you are entitled to extend COBRA coverage. If you don't provide satisfactory evidence within 15 business days of request from us, we 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.**

Submission Options

✓ **Option 1: Email**:
1. Go to https://accesshma.com
2. Click the **Download pdf** option under **COBRA Notice of Second Qualifying Event Form** and fill out the form in compatible software like Adobe Reader/Acrobat
3. Email your completed form and all supporting material to: COBRArequest@accesstpa.com

✓ **Option 2: Mail** the completed form and all supporting material, postmarked by the **Submission Deadline**, to:
HMA
Attn: COBRA
PO Box 53168
Bellevue, WA 98015-3168

Any questions? We're here to help! Contact Customer Care at (800) 869-7093.

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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".*

Employee's Qualifying Event Information

Select the **one** initial qualifying event that started the employee's COBRA coverage and enter the date.

○ Termination *OR* ○ Reduction in Hours **Date of Qualifying Event** (mm/dd/yyyy) _____

Qualified Beneficiary Information

List all beneficiaries who lost group health coverage (but are still receiving COBRA coverage) due to the employee's event above. If you need to list more people than this space allows, include an attachment listing all of the information below for each additional person.

Full Name (first, middle, last)	**Mailing Address** (if different from the employee's)
	☐ *Same as employee*
	☐ *Same as employee*
	☐ *Same as employee*

Second Qualifying Event Information

Select the **one** applicable second qualifying event (A, B, or C) 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*

You're required to include a copy of the decree of divorce / legal separation (whichever of these applies to you). Check this box to confirm you understand this requirement and will include this document with your submission. ☐ I understand this requirement and I'm including this document with my submission.

Note: If you have other insurance and haven't provided us with your other insurance information in the past year, please also fill out and submit the **Other Health Insurance Coverage Form** (located at https://www.accesshma.com/news-and-resources/member-forms)

○ **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"): _____

○ **Event C:** Death of Covered Employee on (mm/dd/yyyy): _____

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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	Email Address

☐ *Same as employee*

Mailing Address

Signature	Date	Relationship to Employee

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.