COBRA

Notice by Qualified Beneficiaries of Second Qualifying Event

IMPORTANT: An extension of COBRA coverage for up to 36 months (from the date of the first qualifying event) may be available to spouses and dependent children who elect COBRA if a second qualifying event occurs during the first 18 months of COBRA coverage. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. For this extension to apply, you must deliver this notice to us at:

Plan Administrator's Name	Address	City	State	Zip

within 60 days after the second qualifying event or within 60 days after the date coverage is lost under the Plan because of the event, whichever is later. **If you do not deliver this notice by the due date above, you will lose your right to an extension of COBRA continuation coverage.** Please refer to the summary plan descriptions for your group health plan(s) for more information about COBRA continuation coverage.

Group Health Plan Information:

Please check the group health plans (the "Plan") under which you have COBRA coverage: ☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER		
EMPLOYEE'S STREET ADDRESS	CITY		STATE	ZIP	
DATE OF TERMINATION/REDUCTION IN HOURS MM/DD/YYYY					

Qualified Beneficiary Information:

Please complete the information below for each person (any spouse or dependent children) who has COBRA coverage:

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER		
STREET ADDRESS		CITY		STATE	ZIP
RELATIONSHIP TO EMPLOYEE					

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER		
STREET ADDRESS		CITY		STATE	ZIP
RELATIONSHIP TO EMPLOYEE					

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER		
STREET ADDRESS		CITY		STATE	ZIP
RELATIONSHIP TO EMPLOYEE					

Notice of Second Qualifying Event:

Please check the event that occurred and give the date it occurred:

☐ DIVORCE OF THE EMPLOYEE AND SPOUSE* ☐ DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD ☐ DEATH OF EMPLOYEE *IF THE EVENT IS A DIVORCE, YOU MUST INCLUDE A COPY OF THE DIVORCE DECREE WITH THIS NOTICE.	DATE OF SECOND QUALIFYING EVENT: MM/DD/YYYY

SIGNATURE	PRINT NAME	DATE