# Notice of COBRA Qualifying Event

A qualified beneficiary (covered employee, covered spouse or covered child) should use this form to report an event that may result in continuation of coverage under Health, Dental, Dental Plus, Vision and/or MoneyPlus Medical Spending Account. It is the qualified beneficiary's responsibility to notify the benefits office within 60 days of the event or the date coverage would have been lost under the plan, whichever is later. **Return the completed form to the employee's benefits office. Failure to complete and submit this form to the benefits office by the deadline stated above will result in the loss of any rights to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).**

**Employee who was covered under PEBA insurance benefits:**_____

**BIN or SSN of employee who was covered:** _____

**Name of qualified beneficiary making this report:** _____

**Relationship to employee:**_____

## Identify the qualifying event. Check applicable box(es) and complete information.

❑ **Covered employee and spouse (qualified beneficiary): ❑ divorced ❑ separated.**
Name of spouse: _____

Address of spouse: _____

Date of divorce or legal separation: _____

***Important:*** *Include a copy of the signed divorce decree or signed court order showing a legal separation.*

❑ **Death of covered employee.**
Date of covered employee's death: _____

***Important:*** *Include a copy of the death certificate.*

❑ **Employee's child (qualified beneficiary) lost eligibility.**
Name of child who ceased to be eligible: _____

Date child ceased to be eligible: _____ due to:

- ❑ Reaching age 26.
- ❑ An incapacitated child age 26 or older who:
  - ❑ Marries.
  - ❑ Is no longer principally (at least 50 percent) dependent on the subscriber.
  - ❑ Is no longer incapacitated.

**I hereby certify that the above information is true and correct.**

_____ _____

Signature of qualified beneficiary making this report (if a minor, then parent) Date