

Employer  Date of Qualifying Event  -  -

## 1. Family Member(s) Losing Coverage (Complete separate forms for Family Members at different addresses)

Name (First, Middle Initial, Last)  Female  Male   
 Date of Birth  -  -  Relationship  -  -   
 Social Security Number  -  -   
 Address  Phone  -  -   
 City  State  Zip

	Other Family Member Names (at same address)	Relationship	Social Security Number	Date of Birth
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please attach sheet for additional Family Members at same address.

## 2. Current Benefits

<input type="checkbox"/> <b>Health</b>	<input type="checkbox"/> <b>Dental</b>	<input type="checkbox"/> <b>Vision</b>
Carrier Name <input type="text"/>	Carrier Name <input type="text"/>	Carrier Name <input type="text"/>
Plan Description <input type="text"/>	Plan Description <input type="text"/>	Plan Description <input type="text"/>
Coverage Level <input type="text"/>	Coverage Level <input type="text"/>	Coverage Level <input type="text"/>
Original Effective Date <input type="text"/>	Original Effective Date <input type="text"/>	Original Effective Date <input type="text"/>
Last Date of Coverage <input type="text"/>	Last Date of Coverage <input type="text"/>	Last Date of Coverage <input type="text"/>
<input type="checkbox"/> <b>Medical Spending Account</b>	<input type="checkbox"/> <b>Other Health Plan</b>	<input type="checkbox"/> <b>Life Insurance</b>
Annual Election \$ <input type="text"/>	Carrier Name <input type="text"/>	Original Effective Date <input type="text"/>
Benefit Last Date of Coverage <input type="text"/>	Plan Description <input type="text"/>	Last Date of Coverage <input type="text"/>
Plan Year Start Date <input type="text"/>	Coverage Level <input type="text"/>	Premium Amount \$ <input type="text"/>
Plan Year End Date <input type="text"/>	Original Effective Date <input type="text"/>	Face Amount \$ <input type="text"/>
Account Paid Through Date <input type="text"/>	Last Date of Coverage <input type="text"/>	<input type="checkbox"/> <b>Medicare Coverage</b>
Year-to-Date Deduction Amount <input type="text"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Please note: Original effective date of coverage is required for all benefits due to the requirements included in the Health Insurance and Accountability Act.

If yes, Effective Date

## 3. Employee Information

Employee Name (First, Middle Initial, Last)  Female  Male   
 Date of Birth  -  -  Employee ID  Social Security Number  -  -   
 Address  Phone  -  -

## 4. Qualifying Event

Divorce  Child Losing Dependent Status  
 Legal Separation  Death of Covered Employee

## 5. Completed By

Name (First, Middle Initial, Last)  Date  Phone



## Instructions for Completing and Submitting This Form

Complete and submit this form to provide notice to your COBRA Administrator of a "qualifying event" or a "second qualifying event", whichever may be applicable. Please read the instructions below carefully. **Failure to follow the instructions may result in a loss of COBRA entitlement.**

### Notice of a Qualifying Event

For the qualifying events; **divorce or legal separation** of the employee and spouse or a **dependent child's losing eligibility** for coverage as a dependent child, you must notify your COBRA Administrator. In providing this notice, complete this form entitled "Employee/Spouse/Dependent Notice of Qualifying Event Form" and mail or hand deliver to the COBRA Administrator using the contact information provided below. The Plan requires you to notify your COBRA Administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

If this notice is not post-marked or hand delivered to the COBRA Administrator within the 60-day notice period, you will lose your right to elect COBRA.

### Notice of a Second Qualifying Event

An extension of coverage will be available to spouses and dependent children who are currently receiving COBRA coverage if a **second qualifying event** occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the **death of a covered employee, divorce or legal separation** from the covered employee or a **dependent child's ceasing to be eligible** for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the COBRA Administrator using the contact information provided below in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the form entitled "(Employee/Spouse/Dependent Notice of a Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified on the form.

Failure to follow the procedures or failure to provide the notice in writing to the COBRA Administrator during the 60-day notice period will result in a loss of entitlement for the second qualifying event extension.

### COBRA Administrator Address & Contact Information

Discovery Benefits-COBRA  
3216 13<sup>th</sup> Ave S  
PO Box 869  
Fargo, ND 58107-0869

Toll Free: 866.451.3399  
Phone: 701.451.3399  
Web Site: [discoverybenefits.com](http://discoverybenefits.com)

### Questions?

For information about your COBRA rights and obligations under the Plan, you should review the Plan's Summary Plan Description or contact COBRA-Plus®, the COBRA administrator. COBRA contact information is provided above.

If you have additional questions about your COBRA continuation coverage, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).