Washington Counties Insurance Fund

Employee's Notice to Employer of a Qualifying Event (or Other Event) that May Affect Entitlement or Duration of COBRA Coverage

(Consolidated Omnibus Budget Reconciliation Act of 1986)

Submit this form to your Human Resources Department to notify your employer of a qualifying event or other event that may affect entitlement or duration of your dependent(s)' continuation coverage under your group health plan. **You must provide this notice to your Human Resources Department within 60 days of the event's occurrence.** Include evidence of the qualifying event (i.e., a certified copy of a divorce decree, a court order of legal separation, a Social Security determination, etc.)

EMPLOYEE INFORMATION

Employee Name: *(full)*	Social Security #:		Date of Birth:	Phone #:
Address:	City:	State:	ZIP:	Email Address:

EVENT INFORMATION

Select the event from below: | Date event occurred (or will occur):

☐ Divorce or legal separation *(if checked complete the following)*

Was the dependent dropped from coverage in anticipation of the divorce or separation? ☐ Yes ☐ No
If **YES**, on what date was the dependent dropped from coverage? Date: ____

☐ Dependent child lost coverage as a result of no longer meeting definition of "dependent" under WCIF eligibility rules

☐ Social Security Administration determination that employee is disabled

☐ Social Security Administration determination that employee is *no longer* disabled

☐ Newborn(s) or child(ren) placed for adoption added during parent's continuation coverage

DEPENDENT INFORMATION

The following dependent(s) is/are affected by the above event:

DEPENDENT INFORMATION					**ENROLLED IN:**			
					Medical	Dental	Vision	EAP
#1	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐	☐	☐	☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** include below)*				
#2	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐	☐	☐	☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** include below)*				
#3	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐	☐	☐	☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** include below)*				

OTHER ADDRESS | If you checked **NO** under *Same Address as Employee* for any dependents, complete the following.

Address:	City:	State:	Zip:

Dependents under other address *(as listed above)*: ☐ **#1** ☐ **#2** ☐ **#3**

If you have additional dependents and/or additional dependent addresses, you may include them on a separate sheet of paper.

SIGNATURE

I certify that the above information is true and correct.

Signature: _____ Date: _____

Name (print): _____ Phone #: _____

Return this notice to your Human Resources Department.

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