COBRA NOTICE
TO PLAN ADMINISTRATOR
OF QUALIFYING EVENT
(EMPLOYEE, SPOUSE OR DEPENDENT CHILD)

Covered employees, spouses and/or dependents who desire continued medical, dental, or vision insurance coverage should complete this form and submit it to the Trust within 60 days of a loss of health care coverage due to a Qualifying Event (see list of Qualifying Events below). Failure to comply within the specified period of time will make you ineligible for continued health care coverage. A covered Employee, Spouse, or Dependent Child, or legal representative, may provide this notice on behalf of the Covered Employee or any other covered individual.

INSTRUCTIONS: Please complete this form and mail or deliver to:

Mail completed Election Form to:
United Employees Benefit Trust
PO Box 8130
Tacoma WA 98418

Hand deliver Election Form to:
United Employees Benefit Trust
220 S 27th St, Ste B
Tacoma WA 98402

This form is being submitted by the: ❑ Employee ❑ Spouse ❑ Dependent Child

Your Name _____ SS# _____

Address _____ City _____

State _____ Zip _____ Phone (Home) _____ (Work) _____

Name of Employer _____

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Name of Employee (if different) _____ SS# _____

Address _____ City _____

State _____ Zip _____ Phone (Home) _____ (Work) _____

Name of Employer _____

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DEPENDENT INFORMATION: (List Spouse and Dependent Children for whom continuation coverage is being requested)

Name	Relationship	Birthdate	Social Security #

Address of:

Spouse/Dependents (if different from above)	City	State	Zip

Please indicate applicable qualifying event(s):

Date of Event

_____ Death of employee (please provide death certificate)
_____ Legal separation (please provide documentation)
_____ Divorce (please provide Divorce Decree)
_____ Dependent child no longer qualified
_____ Second qualifying event (for example, divorce following termination of employment; please provide documentation)
_____ Social Security determined Employee disabled during first 60 days of COBRA coverage; or Employee no longer disabled (please provide documentation)

Other: You may also use this form to notify the Trust of the following qualifying events: Termination of employment, reduction in hours of work such that you are no longer eligible for coverage, loss of coverage due to illness or injury, or employer bankruptcy. Please indicate what the qualifying event is. If illness or injury is involved, please state whether or not the employee is on FMLA. If your employment was terminated, please state whether or not the employer is claiming gross misconduct.

Date of Event

_____ Termination of employment
_____ Termination due to gross misconduct
_____ Reduction in employee's hours worked
_____ Loss of coverage due to illness/injury
_____ Employer bankruptcy
_____ FMLA

If you need assistance in completing this form, please contact the Trust office at (253) 474-1214 or 1(800) 223-2449.

For UEBT Use Only
Date Notice received: _____ Date of Postmark: _____