



COBRA NOTICE of QUALIFYING EVENT BY EMPLOYER

Instructions:

Complete, date, sign and mail this COBRA Qualifying Event Notice by Employer to United Employees Benefit Trust **within 30 days** after any of the following events occurs.

Check the applicable box:

- Covered employee's employment terminates for reasons other than gross misconduct.
 - Voluntary Termination (reason: _____)
Did the employee retire? ___ Yes ___ No
 - Involuntary Termination (reason: _____)
- Hours of work of the covered employee have been reduced below the minimum required for coverage. Reason for the reduction in hours (lack of work, on the job injury, illness, etc.):

- Has the employee requested FMLA leave? ___ Yes ___ No
- A covered employee dies while employed.
- Employee has become eligible for Medicare.
- Employer has filed petition for bankruptcy under Title 11, U.S.C.
- Other (please provide explanation) _____

Identify the Covered Employee:

Print name of employee _____
 Address of employee _____
 City _____ State _____ Zip _____
 Name of Employer _____ Date of the Event: _____

UEBT benefits are to terminate on (mm/01/yyyy): _____

Form completed by:

Print Name _____

Signature

Date

Submit this completed COBRA Qualifying Event Notice:

Facsimile (253) 474-7180 E-mail staff@unitedemployees.org
 United Employees Benefit Trust * PO Box 8130 * Tacoma WA 98419

For UEBT Use Only

Date Notice received: _____ Date of Postmark: _____