COBRA NOTICE of QUALIFYING EVENT by EMPLOYER

Qualifying Event and Date of Qualifying Event:

Complete *(in its entirety)* and return this COBRA Notice of Qualifying Event by Employer to United Employees Benefit Trust **within 30 days** after a qualifying event 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) _____

Date of the Qualifying Event (*usually the last day worked*):_____

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

Employee Information:

Name_____

Address_____

City_____ State_____ Zip_____

Phone Number(s)_____

Employer Information:

Employer Name_____

Form completed by_____

_____ _____
Signature   Date

1/2025