COBRA Qualifying Event Notice

A Lexis Practice Advisor® Practice Note by
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FORM SUMMARY

This form is an event notice used by participants of group health plans and COBRA qualified beneficiaries. It is used to notify the COBRA administrator of certain events that can affect eligibility for COBRA continuation coverage. This form includes practical guidance and drafting notes.

The requirement to use a specific form to provide this notice may form part of a plan's reasonable COBRA administration procedures under federal law, provided that the form is easily available to covered employees and other qualified beneficiaries without cost. 29 C.F.R. § 2590.606-3(b)(3).

For a general practice note on COBRA, see COBRA Compliance and Enforcement. See also the following COBRA compliance flowcharts: COBRA Notice Flowchart (Employee Loss of Coverage); COBRA Notice Flowchart (Spouse or Child Loss of Coverage); COBRA Second Qualifying Event Flowchart; and COBRA Disability Extension Flowchart.

When to Use this Notice: Use this form to report an event affecting eligibility for COBRA continuation coverage under the *[name of plan(s) for which continuation coverage is available]* (the Plan). Keep a copy of this form for your files.

Notice Instructions:

(1) Insert your name and address and the name and address of any individual(s) for whom you are reporting an event.

(2) Check the box next to the event you are reporting.

(3) Go to the numbered section of this form indicated for the applicable event, and complete the requested information. (Do not complete the information for any other sections.)

(4) Sign and date the form where indicated at the bottom.

Mail or hand deliver the signed and completed form (along with any required enclosures) to *[name of COBRA Administrator]*, the COBRA Administrator for the Plan, within the time period described in the applicable section at the following address: *[COBRA Administrator address]*

If you have any questions about this form, contact the COBRA Administrator at *[COBRA Administrator contact information]*.

Notice of COBRA Event

Name and Address

I , _____, am submitting this COBRA Event Notice form to report the event noted below for (check one) _____ myself or _____ the following individual(s): _____ (insert name; use box below for any additional individuals).

My mailing address is:_____

Mailing address for other individuals listed on this form (if different from my own):

_____

COBRA Event

[_] I or the individual(s) listed above have been determined by the Social Security Administration to have become disabled during the first 60 days of COBRA continuation coverage. If you check this box, go to **Section 1.** of this form, below.

[_] I or the individual(s) listed above have been determined by the Social Security Administration as no longer being disabled. If you check this box, go to **Section 2.** of this form, below.

[_] Divorce or legal separation of covered employee (as first COBRA qualifying event). If you check this box, go to **Section 3.** of this form, below.

[_] Dependent-child has stopped being eligible for coverage under the Plan (as first COBRA qualifying event). If you check this box, go to **Section 4.** of this form, below.

[_] Occurrence of one of the following qualifying events during a period of COBRA continuation coverage (a "second qualifying event"): (1) death of covered employee; (2) covered employee has become entitled to Medicare; (3) divorce or legal separation of covered employee; or (4) child ceasing to be an eligible dependent-child under the terms of the Plan. If you check this box, go to **Section 5.** of this form, below.

[_] Obtaining other group health coverage or Medicare entitlement. If you check this box, go to **Section 6.** of this form, below.

Drafting Note to COBRA Event Section:

It is rare for a group health plan to terminate the coverage of an employee or the employee's spouse or dependents under the plan because the employee becomes eligible for Medicare. If entitlement for Medicare does not trigger any loss of coverage under the plan (other than early termination of COBRA continuation coverage), then you should remove item (2) in the list of second qualifying events under the fifth event description. If the plan does not terminate COBRA continuation coverage as a result of a qualifying beneficiary becoming entitled to Medicare, delete "or Medicare entitlement" from the sixth event description.

1. **Notification of Disability**

By signing below, I am notifying the COBRA Administrator that (check one) _____ I or _____ the individual(s) listed in this form have been determined to be disabled by the Social Security Administration and the date on which the person became disabled occurred within the first 60 days of the person's COBRA continuation coverage. I have included a copy of the determination from the Social Security Administration with this form.

Due date: I understand that I have **60 days** from the latest of the following dates to mail or hand deliver this form to the COBRA Administrator: (1) the date on which the Social Security Administration issued the disability determination; (2) the date of the covered employee's termination of employment or reduction in hours; or (3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the covered employee's termination of employment or reduction in hours. **NOTE:** this form must be provided within 18 months of the covered employee's termination of employment or reduction in hours.

Drafting Note to Section 1. Due Date:

Participants and qualified beneficiaries must be notified of their responsibility to provide notice of the COBRA events to the COBRA Administrator and the procedures for doing so (e.g., in the summary plan description or in the initial general COBRA notice). If this notice has not been provided, then the due date for notifying the COBRA Administrator in this paragraph is extended to **60 days** from the date the qualified beneficiary receives notice from the COBRA Administrator, if such date is later than the due date set forth in this paragraph.

2. **No Longer Disabled Notification**

By signing below, I am notifying the COBRA Administrator that (check one) _____I or _____ the individual(s) listed in this form have been determined to no longer be disabled by the Social Security Administration. I have included a copy of such determination from the Social Security Administration with this form.

Due date: I understand that I have **30 days** from the date of receiving the determination from the Social Security Administration to mail or hand deliver this form to the COBRA Administrator.

Drafting Note to Section 2. Due Date:

Participants and qualified beneficiaries must be notified of their responsibility to provide notice of the COBRA events to the COBRA Administrator and the procedures for doing so (e.g., in the summary plan description or in the initial general COBRA notice). If this notice has not been provided, then the due date for notifying the COBRA Administrator in this paragraph is extended to **30 days** from the date the qualified beneficiary receives notice from the COBRA Administrator, if such date is later than the due date set forth in this paragraph.

3. **Divorce or Legal Separation**

By signing below, I am notifying the COBRA Administrator that the covered employee _____ (insert name) has (check one) _____ divorced or _____ legally separated from the covered employee's former spouse, _____ (insert name), on _____ (insert date of divorce decree or legal separation). If the former spouse's health coverage under the Plan was reduced or eliminated before the final divorce decree or legal separation, the date the coverage was reduced or eliminated was: _____ (insert date). I have included with this form a copy of the decree of divorce or legal separation.

Due date: I understand that I have **60 days** from the later of (1) the date of the decree of divorce or legal separation or (2) the date that the covered former spouse loses (or would lose) coverage under the Plan to mail or hand deliver this form to the COBRA Administrator.

Drafting Note to Section 3. Due Date:

Participants and qualified beneficiaries must be notified of their responsibility to provide notice of the COBRA events to the COBRA Administrator and the procedures for doing so (e.g., in the summary plan description or in the initial general COBRA notice). If this notice has not been provided, then the due date for notifying the COBRA Administrator in this paragraph is extended to 60 days from the date the qualified beneficiary receives notice from the COBRA Administrator, if such date is later than the due date set forth in this paragraph.

4. **Dependent-Child Loss of Eligibility**

By signing below, I am notifying the COBRA Administrator that _____ (insert name of ineligible child), with a date of birth of _____ (insert date of birth), is no longer eligible as a dependent-child under the terms of the Plan.

Due date: I understand that I have **60 days** from the later of (1) the date this individual ceased to be eligible as a dependent-child under the terms of the Plan or (2) the date that this individual loses (or would lose) coverage under the Plan to mail or hand deliver this form to the COBRA Administrator.

Drafting Note to Section 4. Due Date:

Participants and qualified beneficiaries must be notified of their responsibility to provide notice of the COBRA events to the COBRA Administrator and the procedures for doing so (e.g., in the summary plan description or in the initial general COBRA notice). If this notice has not been provided, then the due date for notifying the COBRA Administrator in this paragraph is extended to **60 days** from the date the qualified beneficiary receives notice from the COBRA Administrator, if such date is later than the due date set forth in this paragraph.

5. **Second Qualifying Event**

By signing below, I am notifying the COBRA Administrator that _____ (insert name of qualified beneficiary) became entitled to COBRA continuation coverage due to a covered employee's termination of employment or reduction in hours for a maximum period of 18 (or 29 months, in the case of disability extension), and the qualified beneficiary experienced one of the following second qualifying events as a result of which the qualified beneficiary would lose coverage under the Plan if the first qualifying event had not occurred:

[_] Death of the covered employee on _____ (insert date of death).

[_] Divorce or legal separation of the covered employee. Please provide a copy of the divorce decree or decree of legal separation. In the event that the former spouse's coverage was reduced or eliminated in anticipation of a divorce or legal separation, please provide the date of such reduction or elimination here: _____.

[_] Medicare entitlement of the covered employee (in certain circumstances) on _____ (insert date). Please provide documentation that shows Medicare entitlement.

[_] Loss of the qualified beneficiary's dependent-child status under the Plan on _____ (insert date eligibility stopped). Please provide the date of birth of the qualified beneficiary: _____.

Due date: I understand that I have **60 days** from the later of (1) the date of the second qualifying event or the (2) date that this individual loses (or would lose) coverage under the Plan to mail or hand deliver this form to the COBRA Administrator.

Drafting Note to Section 5. Due Date:

Participants and qualified beneficiaries must be notified of their responsibility to provide notice of the COBRA events to the COBRA Administrator and the procedures for doing so (e.g., in the summary plan description or in the initial general COBRA notice). If this notice has not been provided, then the due date for notifying the COBRA Administrator in this paragraph is extended to **60 days** from the date the qualified beneficiary receives notice from the COBRA Administrator, if such date is later than the due date set forth in this paragraph.

6. **Other Plan Coverage or Medicare Entitlement**

By signing below, I am notifying the COBRA Administrator that since the date COBRA coverage was initially elected under the Plan, (check one) _____ I or _____the individual(s) listed above became (check one):

[_] covered under another group health plan, on _____ (insert date coverage began), or

[_] entitled to Medicare, on _____ (insert first date of Medicare entitlement).

Due date: I understand that I have **30 days** from the date the other coverage became effective or the date of Medicare entitlement to mail or hand deliver this form to the COBRA Administrator.

Drafting Note to Section 6. (Other Plan Coverage or Medicare Entitlement):

If the plan does not terminate COBRA continuation coverage as a result of a qualifying beneficiary becoming entitled to Medicare, remove references to Medicare entitlement from this section.

Signature and Date

By signing below, I attest that the information provided in and with this form is true and correct. In the event that I later determine that any of the information above is incorrect, I will immediately notify the COBRA Administrator.

Signed: _____

Print name here: _____

Date: _____

This form must be completed and postmarked or hand delivered by the due date described in the applicable section. If this form is mailed or delivered after the due date, it will not be accepted and any period of COBRA coverage that may have been available as a result of the reported event will be denied.

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Gabriel Marinaro serves as special counsel in the Employee Benefits and Executive Compensation group. His practice focuses on all aspects of employee benefits and executive compensation. He regularly counsels publicly traded and privately held companies, tax-exempt organizations, and governmental entities on a variety of employee benefits and executive compensation matters. Gabe regularly advises both employers and executives on a wide range of executive compensation matters, including drafting employment agreements, equity compensation arrangements, severance agreements and bonus plans. Gabe provides guidance on nonqualified deferred compensation plans both for for-profit companies and tax-exempt clients. Gabe regularly drafts nonqualified deferred compensation arrangements, including supplemental executive retirement plans, and change in control agreements. Additionally, Gabe advises employers and executives on issues under Code Sections 409A, 457(f), 457A, 162(m), 280G and 83 regarding compensation arrangements for executives.

Gabe assists both publicly traded and privately held companies with equity compensation matters, including drafting equity incentive plans, securities filings, award agreements, and other documentation surrounding the implementation of an equity incentive plan and the underlying awards. Gabe also has drafted and advised on profits interests plans and unit appreciation rights plans for limited liability companies.