bac

COBRA – NOTICE OF QUALIFYING EVENT

REQUIRED NOTICE BY COVERED EMPLOYEE AND/OR DEPENDENT (QUALIFIED BENEFICIARY) REGARDING CONTINUATION COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED ("COBRA")

I. INSTRUCTIONS

In order to be eligible to continue coverage, this notice must be provided to the Plan Administrator whenever any of the following events occur and you, your spouse, or your dependent child loses coverage under the Plan:

1. **The divorce or legal separation of you and your spouse.** ***Complete the following items 1, 2 and 8.***
2. **Your Medicare entitlement.** ***Complete the following items 1, 3 and 8.***
3. **Your child has ceased to be a dependent under the terms of the Plan.** ***Complete the following items 1, 4 and 8.***
4. **Employee's death.** ***Complete the following items 1, 5 and 8.***
5. **The Social Security Administration ("SSA") has determined that you, your spouse, or your dependent child was disabled on any day of the first 60 days of COBRA Continuation Coverage.** ***Complete the following items 1, 6 and 8.***
6. **The maximum period of COBRA Continuation Coverage was extended for up to 11 months due to your, your spouse's, or your dependent child's disability, but the SSA later has determined that he or she is no longer disabled.** ***Complete the following items 1, 7 and 8.***

When any of the above events occur (the "Event"), you, your spouse, or your child must complete, date, sign and mail, by U.S. First Class Mail, or hand deliver, this notice to Business Administrators & Consultants, Inc. (BAC), Plan Supervisor, on behalf of the Plan Administrator.

Hand deliver to: BAC
Plan Supervisor
6331 East Livingston
Reynoldsburg, Ohio 43068
(614) 863-8780

Mail to: BAC
Plan Supervisor
P.O. Box 107
Reynoldsburg, Ohio 43068
(800) 521-2654

II. DEADLINES

IF YOU ARE PROVIDING NOTICE OF:	THE DEADLINE FOR PROVIDING THIS NOTICE IS:
• Divorce or legal separation of you and your spouse, • Your Medicare entitlement, • Employee's death, or • Your child's cessation of eligibility as a dependent under the terms of the Plan.	**60 days after the latest of:** • Date of the Event, • Date on which you, your spouse or your child loses (or would lose) coverage under the Plan as a result of the Event, or • Date on which you, your spouse, or your child is informed (through the Plan's Summary Plan Description ("SPD") or the general notice) of the responsibility and procedures for this notice.
• Disability determination by the SSA	**60 days after the latest of:** • Date of the SSA's disability determination, • Date of the Event, • Date on which you, your spouse, or your child loses (or would lose) coverage under the Plan as a result of the Event, or • Date on which you, your spouse, or your child is informed (through the Plan's SPD or the general notice) of the responsibility and procedures for this notice. **In any event,** this notice must be provided within the initial 18-month COBRA Continuation Coverage period.
• Determination by the SSA that you, your spouse, or your child is no longer disabled	**30 days after the later of:** • Date of the SSA's final determination that you, your spouse, or your child is no longer disabled, or • Date on which you, your spouse, or your child is informed (through the Plan's SPD or the general notice) of the responsibility and procedures for this notice.

Your notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline. **If your notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.**

This notice may be provided by you (as a Covered Employee or former employee), your spouse, or your child or any representative acting on behalf of you, your spouse, or your child. The provision of this notice by one individual shall satisfy any responsibility to provide notice on behalf of you, your spouse, or your child individually with respect to the Event.

III. EMPLOYEE AND PLAN INFORMATION:

1.

NAME OF EMPLOYER:

NAME OF PLAN OR NAME OF PLAN SPONSOR/EMPLOYER AS IT APPEARS ON BENEFIT I.D. CARD:

COVERED OR FORMER EMPLOYEE'S NAME (LAST, FIRST, M.):	SOCIAL SECURITY NUMBER:

COVERED OR FORMER EMPLOYEE'S ADDRESS:	CITY:	STATE:	ZIP CODE:

IS THIS A NEW ADDRESS?:	PHONE NUMBER:	DATE OF BIRTH (MM/DD/YYYY):	EMAIL ADDRESS:

IF YOU, YOUR SPOUSE OR YOUR DEPENDENT CHILD ALREADY ARE RECEIVING COBRA CONTINUATION COVERAGE AND WISH TO EXTEND THE MAXIMUM COVERAGE PERIOD, IDENTIFY THE INITIAL QUALIFYING EVENT:

INITIAL QUALIFYING EVENT:	DATE OF QUALIFYING EVENT:

IV. EVENT DESCRIPTION (CHECK ONE AND COMPLETE):

2.

DIVORCE OR LEGAL SEPARATION:	DATE OF DIVORCE / SEPARATION:
◯ **YOUR DIVORCE FROM YOUR SPOUSE** ◯ **YOUR LEGAL SEPARATION FROM YOUR SPOUSE**	

PRINT NAME OF SPOUSE COVERED UNDER THE PLAN (LAST, FIRST, M.):

PRINT NAME(S) OF DEPENDENT CHILD(REN) COVERED UNDER THE PLAN (LAST, FIRST, M.):

_____ _____

_____ _____

ADDRESS OF SPOUSE AND DEPENDENT CHILD(REN):

◯ **SAME AS COVERED EMPLOYEE'S (OR FORMER EMPLOYEE'S) ADDRESS** ◯ **DIFFERENT ADDRESS (PROVIDE ADDRESS BELOW)**

ADDRESS:	CITY:	STATE:	ZIP CODE:

IS A COPY OF THE DECREE OF DIVORCE OR LEGAL SEPARATION ENCLOSED WITH THIS NOTICE?:

◯ **NO*** ◯ **YES**

* YOU MUST PROVIDE A COPY OF THE DECREE OF DIVORCE OR LEGAL SEPARATION. HOWEVER, IF YOU CANNOT PROVIDE THE DECREE BY THE DEADLINE (SEE ABOVE) FOR PROVIDING THIS NOTICE, COMPLETE AND PROVIDE THIS NOTICE, AS INSTRUCTED, BY THE DEADLINE AND SUBMIT THE DECREE WITHIN 30 DAYS AFTER THE DEADLINE. YOUR NOTICE WILL BE TIMELY IF YOU DO SO. HOWEVER, NO COBRA CONTINUATION COVERAGE, OR EXTENSION OF SUCH COVERAGE, WILL BE AVAILABLE UNTIL A COPY OF THE DECREE IS PROVIDED.

3.

ENTITLEMENT TO MEDICARE:	DATE OF ENTITLEMENT:	PRINT NAME OF SPOUSE COVERED UNDER THE PLAN (LAST, FIRST, M.):
◯ **MEDICARE ENTITLEMENT**		

PRINT NAME(S) OF DEPENDENT CHILD(REN) COVERED UNDER THE PLAN (LAST, FIRST, M.):

_____ _____

_____ _____

ADDRESS OF SPOUSE AND DEPENDENT CHILD(REN):

◯ **SAME AS COVERED EMPLOYEE'S (OR FORMER EMPLOYEE'S) ADDRESS** ◯ **DIFFERENT ADDRESS (PROVIDE ADDRESS BELOW)**

ADDRESS:	CITY:	STATE:	ZIP CODE:

4.

CHILD HAS CEASED TO HAVE DEPENDENT STATUS:

◯ **A CHILD WHO IS COVERED UNDER THE PLAN HAS CEASED TO BE A DEPENDENT UNDER THE TERMS OF THE PLAN.**

PRINT NAME OF CHILD COVERED UNDER THE PLAN (LAST, FIRST, M.):	DATE OF TERMINATION/EVENT:

REASON CHILD CEASED TO BE ELIGIBLE DEPENDENT (CHECK ONE):

◯ **ATTAINED THE AGE OF:** ◯ **LOST STUDENT STATUS** ◯ **MARRIED** ◯ **OTHER – EXPLAIN:**

ADDRESS OF CHILD:

◯ **SAME AS COVERED EMPLOYEE'S (OR FORMER EMPLOYEE'S) ADDRESS** ◯ **DIFFERENT ADDRESS (PROVIDE ADDRESS BELOW)**

ADDRESS:	CITY:	STATE:	ZIP CODE:

5.

COVERED EMPLOYEE'S (OR FORMER EMPLOYEE'S) DEATH:	DATE OF EMPLOYEE'S DEATH:
◯ **DEATH OF COVERED EMPLOYEE.**	

PRINT NAME OF SPOUSE COVERED UNDER THE PLAN (LAST, FIRST, M.):

PRINT NAME(S) OF DEPENDENT CHILD(REN) COVERED UNDER THE PLAN (LAST, FIRST, M.):

_____, _____

_____, _____

ADDRESS OF SPOUSE AND DEPENDENT CHILD(REN):

◯ **SAME AS COVERED EMPLOYEE'S (OR FORMER EMPLOYEE'S) ADDRESS** ◯ **DIFFERENT ADDRESS (PROVIDE ADDRESS BELOW)**

ADDRESS:	CITY:	STATE:	ZIP CODE:

6.

DISABILITY:

◯ **THE SSA HAS DETERMINED THAT YOU, YOUR SPOUSE, OR YOUR DEPENDENT CHILD WAS DISABLED ON ANY DAY OF THE FIRST 60 DAYS OF COBRA CONTINUATION COVERAGE.**

PRINT NAME OF DISABLED INDIVIDUAL (LAST, FIRST, M.):	DATE DISABILITY BEGAN:

ADDRESS OF DISABLED INDIVIDUAL:	CITY:	STATE:	ZIP CODE:

PRINT NAME(S) OF OTHER FAMILY MEMBER(S) COVERED UNDER THE PLAN (LAST, FIRST, M.):

_____, _____

_____, _____

ADDRESS(ES) OF OTHER FAMILY MEMBER(S):

◯ **SAME AS FORMERLY DISABLED INDIVIDUAL'S ADDRESS** ◯ **DIFFERENT ADDRESS (PROVIDE ADDRESS BELOW)**

ADDRESS:	CITY:	STATE:	ZIP CODE:

IS A COPY OF THE SSA'S DETERMINATION ENCLOSED WITH THIS NOTICE?:	DATE OF SSA'S DETERMINATION:
◯ **YES** ◯ **NO***	

* IF YOU, YOUR SPOUSE, OR YOUR CHILD HAS BEEN DETERMINED TO BE DISABLED, PROVIDE A COPY OF THE SSA'S DETERMINATION. HOWEVER, IF YOU CANNOT PROVIDE THE DETERMINATION BY THE DEADLINE (PAGE 1) FOR PROVIDING THIS NOTICE, COMPLETE AND PROVIDE THIS NOTICE, AS INSTRUCTED, BY THE DEADLINE AND SUBMIT THE DETERMINATION WITHIN 30 DAYS AFTER THE DEADLINE. YOUR NOTICE WILL BE TIMELY IF YOU DO SO. HOWEVER, NO EXTENSION OF COBRA CONTINUATION COVERAGE WILL BE AVAILABLE UNTIL A COPY OF THE DETERMINATION IS PROVIDED.

7.

LOSS OF DISABILITY STATUS:

◯ **THE MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE WAS EXTENDED FOR UP TO 11 MONTHS DUE TO YOUR, YOUR SPOUSE'S, OR YOUR CHILD'S DISABILITY, BUT THE SSA LATER HAS DETERMINED THAT THAT INDIVIDUAL IS NO LONGER DISABLED.**

PRINT NAME OF FORMERLY DISABLED INDIVIDUAL (LAST, FIRST, M.):

ADDRESS OF FORMERLY DISABLED INDIVIDUAL: | CITY: | STATE: | ZIP CODE:

PRINT NAME(S) OF OTHER FAMILY MEMBER(S) COVERED UNDER THE PLAN (LAST, FIRST, M.):

ADDRESS(ES) OF OTHER FAMILY MEMBER(S):

◯ **SAME AS FORMERLY DISABLED INDIVIDUAL'S ADDRESS** ◯ **DIFFERENT ADDRESS (PROVIDE ADDRESS BELOW)**

ADDRESS: | CITY: | STATE: | ZIP CODE:

DATE DISABILITY ENDED: | DATE OF SSA'S DETERMINATION:

V. AUTHORIZATION:

8. I AM THE (CHOOSE ONE):

◯ **COVERED EMPLOYEE OR FORMER EMPLOYEE** ◯ **SPOUSE OR FORMER SPOUSE** ◯ **FORMER DEPENDENT CHILD**

◯ **OTHER – PLEASE EXPLAIN:**

PRINT YOUR NAME (LAST, FIRST, M.):

YOUR HOME ADDRESS: | CITY: | STATE: | ZIP CODE:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

X _____ _____

SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

! FOR INTERNAL PLAN USE ONLY:

IF MAILED, DATE OF POSTMARK: | IF HAND DELIVERED, DATE NOTICE RECEIVED:

DECREE ENCLOSED: ◯ **YES** ◯ **NO** ◯ **N/A** | **DETERMINATION ENCLOSED:** ◯ **YES** ◯ **NO** ◯ **N/A**

FOLD HERE FOR USE WITH A NO. 10 WINDOW ENVELOPE

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FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR COMMENTS:

ON THE WEB: **WWW.BACTPA.COM**
TOLL FREE: **1.800.521.2654**
FACSIMILE: **1.614.863.0184**

ANSWER ALL QUESTIONS FULLY, ATTACH DIVORCE DECREE OR SSA DETERMINATION AND MAIL TO BAC FOR PROCESSING:

BUSINESS ADMINISTRATORS & CONSULTANTS, INC.
PO BOX 107
REYNOLDSBURG, OH 43068-0107