**Employee / Qualified Beneficiary**

## Notice of Qualifying Event to Employer / Plan Administrator

Date: _____

Attn: **City of Idaho Falls**
**Attn: Kelly Call**

From: _____

This is my notice to you that the changes and/or events checked below have taken place. I understand that I must provide this notice no later than 30 days after the event or 30 days after the loss of coverage as a result of the change/event, if later). I understand that this notification is required in order to protect COBRA rights for all covered individuals listed below.

- ☐ Divorce/Legal Separation or other termination of marriage on _____.
- ☐ Dependent Child turning Age _____ on _____ .
- ☐ Dependent Child is no longer a qualified dependent as of _____.
- ☐ Other (please describe): _____

This change effects coverage under the following plans:

- ☐ Health Plan
- ☐ Dental Plan
- ☐ Other: _____

This notice effects the following individuals (attach additional sheets if necessary):

| | |
|---|---|
| Name: | |
| Social Security #: | Date of Birth: |
| Mailing Address: | |
| City, State, Zip: | |
| Name: | |
| Social Security #: | Date of Birth: |
| Mailing Address: | |
| City, State, Zip: | |
| Name: | |
| Social Security #: | Date of Birth: |
| Mailing Address: | |
| City, State, Zip: | |

Signature: _____ Date of this Notice: _____

Printed Name: _____ Phone Number: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____