**NOTICE OF SECOND QUALIFYING EVENT**
**ABC Company Welfare Benefits Plan (the Plan)**

**When to Use This Notice:**
Use this Notice if the qualified beneficiary meets both of the following conditions:

1. The qualified beneficiary became entitled to COBRA coverage due to a "qualifying event" that was either the termination of the covered employee's employment or the reduction of the employee's hours of work: AND
2. Any of the following events (called "second qualifying events") occurs:
   - A spouse who is already receiving COBRA coverage becomes divorced or legally separated from the covered employee;
   - A child who is already receiving COBRA coverage ceases to be a dependent under the terms of the Plan; or
   - The covered employee dies while one or more qualified beneficiaries are already receiving COBRA coverage.

**Deadline:**
The deadline for providing this Notice is 60 days after the date of the second qualifying event.

**How, When, and Where to Send Notices: You must mail or hand-deliver your notice to:**
**COBRA Administrator**
**Trinity Marketing Services**
**PO Box 193**
**Marlton, NJ 08053**
However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from the Employer.
*Your Notice must be in writing (using this form) and must be mailed or hand-delivered*. Oral notice, including notice by telephone, is not acceptable. Electronic notices (including emailed or faxed notices) are not acceptable. If you mail the Notice, it must be postmarked on or before the deadline described above. If you hand-deliver the notice, it must be received by the individual at the address specified above on or before the deadline described above.
For more information about this Notice, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's summary plan description, the Plan's COBRA initial notice, and the Plan's COBRA election notice that was provided to you for the qualifying event. (You may obtain copies of these documents from COBRA Administrator.)

**Warning: If your Notice is late, or if it is not completed and provided to COBRA Administrator as described above, no extended COBRA coverage will be available to any qualified beneficiary.**

**Complete This Portion of the Notice:**

**Identify the Covered Employee** (the employee or former employee who is or was covered under the Plan) **and Date of Qualifying Event:**

| Print name of covered employee: | Plan ID#: | Date of birth: |
|---|---|---|
| Address of covered employee: | | |
| Date of qualifying event (date employee's employment terminated or date employee's hours were reduced): | | |

**Identify All Qualified Beneficiaries:**
Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

| Name of qualified beneficiary: | Address of qualified beneficiary: |
|---|---|
| | Address is same as employee's address above<br>Other |
| | Address is same as employee's address above<br>Other |
| | Address is same as employee's address above<br>Other |
| | Address is same as employee's address above<br>Other |
| | Address is same as employee's address above<br>Other |

**Identify Second Qualifying Event** (Check box 1, 2 or 3 and complete the box):

| **1. Second Qualifying Event is: Divorce Legal Separation** | | |
|---|---|---|
| Name of Spouse: | Spouse's Address: | |
| If any child is losing coverage, name of child: | Child's Address:<br>Same as spouse's address<br>Other | |
| Date of divorce or legal separation: | | |
| You must provide a copy of the decree of divorce or legal separation.<br>**Is a copy enclosed?** | | Yes<br>No |
| **2. Second Qualifying Event is: Child has ceased to be an eligible dependent under the Plan** | | |
| Name of Child: | Child's Address:<br>Same as spouse's address<br>Other | |
| Reason child ceased to be eligible dependent [check one]:<br>attained age 26<br>other (explain) | | |
| Date of event causing child's loss of dependent eligibility: | | |
| **3. Second Qualifying Event is: Death of covered employee** | | |
| Date of covered employee's death: | | |

**Contact Information:**

| Print name of person signing this Notice: | I am the (check one):<br>employee or former employee<br>spouse or former spouse<br>former dependent child<br>other (explain) |
| --- | --- |
| Address:<br>Same as employee's address above<br>Same as spouse's address above<br>Same as child's address above<br>Other (enter here) | Telephone number:<br><br>Email address: |

**Certification, Signature, and Date:**

I certify that the above information is true and correct.

NAME: ____________________________ Wet Signature: ____________________

Signature Date: ____________________________

**For Plan Use Only:**

| Date Notice received: | Date of postmark, if mailed: |
| --- | --- |
| Attach original envelope with postmark | Yes No (explain) |
| Divorce decree enclosed? | Yes<br>No<br>N/A |
| Decree of legal separation enclosed? | Yes<br>No<br>N/A |