NOTIFICATION OF A COBRA QUALIFYING EVENT
TO PLAN ADMINISTRATOR

ATTENTION: COVERED EMPLOYEE AND/OR COVERED SPOUSE OR DEPENDENT

Under the rules of the health insurance policy only a spouse or an eligible dependent can be covered by the health plan. If a divorce/legal separation or a dependent ceases to be an eligible dependent, they must be removed from the health plan. This form is to be completed by a covered employee, spouse, or dependent to report the divorce, legal separation or a dependent child ceasing to be a dependent under the terms of the group health plan. This form should be returned to Long Beach City College, 4901 E. Carson Street, Long Beach, CA 90808, Attn: Benefits-G2. Upon notification, appropriate forms will be provided and eligibility for health insurance continuation coverage will be determined.

60 DAY NOTIFICATION REQUIREMENT!
Failure to complete and submit this form within 60 days of the event or from the date of loss of coverage will result in the loss of continuation coverage rights under the federal COBRA law. Should you have any questions as to this form's purpose or how to complete the form, contact the Benefits Office at (562) 938-4531.

INSTRUCTIONS
Step 1: Completely fill out the required information.
Step 2: Attach required documentation copies and copy information for your records.
Step 3: Mail all information to the address listed below.
Step 4: Contact the Benefits Office at (562) 938-4531 within ten days to verify the form has been received.

Please Check One:

☐ ***Divorce/Legal Separation*** ***Date of Event:*** _____
(Attach a copy of the signed divorce decree or legal separation. Form must be postmarked within 60 days of the date of the event or from the plan loss of coverage date, whichever date is later.)

☐ ***Child Ceasing To Be a Dependent*** ***Date of Event:*** _____
Reason: _____
(Form must be postmarked within 60 days of event date or from the plan loss of coverage date, whichever is later.)

☐ ***Second Qualifying Event*** ***Date of Event:*** _____
(Attach documentation of divorce decree/legal separation, death certificate, or a dependent child ceasing to be eligible for coverage under the terms of the group health plan. This form & documentation must be postmarked within 60 days of the date of the 2nd event, otherwise extended continuation coverage rights will be lost.)

☐ ***Social Security Disability*** ***Date of SSA Disability:*** _____
(Attach a copy of the Social Security Disability award which must be postmarked within 60 days from the date the SSA made the determination of disability and it must be within the original 18 months of continuation coverage.)

☐ ***Ceasing To Be Social Security Disabled***
(If the Social Security Administration determines that you are no longer disabled, you must notify the plan administrator within 30 days of this SSA determination. Attach a copy of the SSA determination.)

_____ _____
Signature Date

Mailing Address of Spouse or Dependent:

Name: _____
Street Address: _____
City, State, Zip: _____
Telephone: _____

Mail, Fax, or Hand Deliver the Completed Form To:
Long Beach City College
Benefits Dept. - G2
4901 E. Carson Street
Long Beach, CA 90808
Telephone: 562-938-4531, Fax 562-938-4959