

# DAKOTA WESLEYAN UNIVERSITY

## EMPLOYEE/QUALIFIED BENEFICIARY NOTICE OF A QUALIFYING EVENT

I \_\_\_\_\_ hereby notify Dakota Wesleyan University's plan administrator of a qualifying event that is a:

- \_\_\_\_\_ Divorce or legal separation
  - A copy of the decree must be attached
- \_\_\_\_\_ Loss of a dependent child's eligibility for coverage as a dependent (as defined by plan terms)
  - age 29 or over and not a full time student
  - a dependent child who marries
- \_\_\_\_\_ Social Security Administration determination of a disability
  - the determination date must be prior to the 60<sup>th</sup> day of COBRA
  - a copy of the determination must be attached
  - you must notify us within 30 days of the loss of this determination

The qualifying event or disability determination occurred on \_\_\_\_\_. I realize this notice must be sent to the plan administrator (Director of Human Resources) within 60 days of this event.

The individual(s) affected by the above event is/are:

\_\_\_\_\_ relationship \_\_\_\_\_  
\_\_\_\_\_ relationship \_\_\_\_\_  
\_\_\_\_\_ relationship \_\_\_\_\_  
\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_  
(employee signature) (date) (phone number)

\_\_\_\_\_  
(address) (city) (state) (zip code)

Address and phone number of the affected individual (if different than the above address)

\_\_\_\_\_  
All of the above information must be given or the continuation of health insurance may be denied. As an employee or qualified beneficiary, you are advised to keep a copy of this notice for your records.