QUALIFIED BENEFICIARY'S NOTICE OF QUALIFYING EVENT/EXTENSION EVENT/CESSATION OF DISABLED STATUS

Qualified beneficiaries must notify the Plan Administrator of certain qualifying events in order to be eligible for COBRA continuation coverage under the Kent County Employee and Retiree Benefits Plan ("Plan"). Notification of events that could extend the COBRA continuation period ("extension events") is also required. This form may be used to notify the Plan Administrator of these events.

You should contact the Plan Administrator at the address or telephone number on the second page of this form for information regarding COBRA continuation coverage, the qualifying events and extension events for which notification is required, and the procedures for submitting these notices, including the applicable time limit for submission of each notice.

Instructions

Complete this form, attach any required documentation and return it to the Plan Administrator at the address on the second page of this form. If you are unable to provide any required documentation, include an explanation regarding why the documentation is not available and the date when you anticipate it will be available. **Failure to complete all applicable sections of this form and/or to attach the appropriate documentation or explanation may affect your eligibility for COBRA continuation coverage.**

1. **Employee's Name (print):** _____

2. **Event Identification:** (check applicable box and provide the requested information)

☐ **Divorce/Legal Separation of Employee**

Date of Divorce/Legal Separation: _____

Attach copy of the judgment of divorce or other applicable court documents

NOTE: Legal separation is where a court enters an order of separate maintenance. A couple who separates and files for divorce is not legally separated for COBRA purposes.

☐ **A Child No Longer Meets the Definition of a Dependent Under the Plan**

Name of Affected Child: _____

Date of Loss of Dependent Status: _____
(for example, date of 26th birthday)

☐ **Death of Employee**

Date of Employee's Death: _____

☐ **Employee's Entitlement to Medicare**

Effective Date of Entitlement: _____

Attach a copy of the document(s) establishing the Medicare entitlement/Medicare enrollment

☐ **A Determination that a Qualified Beneficiary is Entitled to Social Security Disability Benefits**

Name of Qualified Beneficiary Entitled to Disability Benefits: _____

Effective Date of Disability Determination: _____

Attach a copy of the determination from the Social Security Administration

☐ **A Final Determination that a Qualified Beneficiary is No Longer Entitled to Social Security Disability Benefits**

Name of Affected Qualified Beneficiary: _____

Effective Date of Final Determination: _____

Attach a copy of the determination from the Social Security Administration

3. **Name and Current Address of All Individuals for Whom COBRA or an Extension of COBRA is Being Requested:** (Attach additional names/addresses if necessary)

Name: _____

Current Address: _____

_____

Name: _____

Current Address: _____

_____

4. **Signature/Certification:** I certify that all the above information is true.

_____ _____

Signature Date

_____

Print Name

Relationship to Employee: (check one) ☐ Self ☐ Spouse/Former Spouse ☐ Dependent Child ☐ Other (explain): _____

Send this completed form and required attachments to:

Kent County Administration
300 Monroe Avenue, N.W.
Grand Rapids, MI 49503
Attn: Human Resources Department
Telephone Number: (616) 632-7440