



**Employee's/Beneficiary's Notice to Employer of COBRA Qualifying Event**

Date of Notice: \_\_\_\_\_

<b>TO:</b>	(Employer)*	<b>Boise School District, ATTN: COBRA Plan Administrator</b>
	(Address)	<b>8169 West Victory Road</b>
	(City, State, Zip Code)	<b>Boise, ID 83709</b>
<b>FROM:</b>	(Employee/Qualified Beneficiary)	
	(Address)	
	(Telephone #)	

\* For most recent address information, check Plan's most recent Summary Plan Description.

Name of Plan: The Independent School District of Boise City Group Health Insurance Plan  
Covered Employee/Qualified Beneficiary Name and Complete Address: \_\_\_\_\_

Date of Qualifying Event: \_\_\_\_\_

**DIVORCE OR LEGAL SEPARATION, DEPENDENT STATUS, SECOND QUALIFYING EVENT**

This notice must be sent to the Plan Administrator after any of the following events occurs. The deadline for providing this notice is **60 days** after the later of (1) the qualifying event or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the qualifying event. Please check the appropriate event:

- A spouse covered under the Plan becomes divorced or legally separated from the covered employee.
- A child covered under the Plan ceases to be a dependent under the terms of the Plan.
- The occurrence of a second qualifying event (i.e., spouse becomes divorced/legally separated, child ceases to be dependent, or employee dies) after the qualified beneficiary has become entitled to COBRA with a maximum duration of 18 or 29 months.

**DISABILITY**

This notice must be sent to the Plan Administrator after the following event occurs. The deadline for providing this notice is **60 days** after the later of (1) the date of the disability determination by the Social Security Administration, (2) the date on which a qualifying event occurs, or (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the qualifying event. This notice must also be provided before the end of the first 18 months of COBRA continuation coverage. Please check the event if applicable:

- A qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage.

**CESSATION OF DISABILITY**

This notice must be sent to the Plan Administrator after the following event occurs. The deadline for providing this notice is **30 days** after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. Please check the event if applicable:

- A qualified beneficiary, previously found to be disabled by the Social Security Administration, has subsequently been determined to no longer be disabled.

**WHO MAY PROVIDE NOTICE**

Any individual who is either the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary may provide this notice. Such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries.

IF THIS NOTICE IS LATE OR INCOMPLETE (I.E., DOES NOT NAME THE PLAN, THE COVERED EMPLOYEE AND QUALIFIED BENEFICIARIES, THE QUALIFYING EVENT OR DISABILITY, AND THE DATE OF THE QUALIFYING EVENT), NO QUALIFIED BENEFICIARIES WILL BE OFFERED THE CHANCE TO ELECT COBRA CONTINUATION COVERAGE.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Please Print Your Name