Notification to Plan Administrator of a COBRA Qualifying Event or Extension

ATTENTION COVERED EMPLOYEE AND/OR COVERED SPOUSE AND DEPENDENT:
This form is to be completed by a covered employee, spouse, or dependent to report qualifying events to the University of Southern California Office of Benefits Administration as required under provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Failure to complete and submit this form in a timely manner will result in a loss of health insurance continuation rights that are available under COBRA. Should you have any questions about this notification, contact the USC Benefits Administration (213-740-6027).

INSTRUCTIONS:
Step 1: Completely fill out the required information.
Step 2: Attach required documentation and copy form and documentation for your records.
Step 3: Mail (or fax) all information to the address listed below and document your mailing.
Step 4: Call USC Benefits Administration within 10 days to insure the form has been received.

Name of Covered Employee: ______________________________

Name of Person Filing this Report: ______________________________

Relationship to Employee: ______________________________

PLEASE CHECK ONE:

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

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

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

☐ **Social Security Disability** **Date of Event:** ______________
(Attach a copy of the Social Security Disability award which must be mailed (postmarked) within 60 day 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** **Date of Event:** ______________
(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 of REPORTEE DATE of NOTIFICATION

Current Mailing Address of Qualified Beneficiary:

Street Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________________

Mail or Fax Completed Form To:
USC Office of Benefits Administration
CUB 200
Los Angeles, CA 90089-0704

Fax: (213) 740-3875