C O B R A

Notice by Qualified Beneficiaries of Initial Qualifying Event

IMPORTANT: If you are a qualified beneficiary and you lost or will lose coverage under one or more of our group health plans because of a qualifying event, you may be eligible for COBRA continuation coverage if you give the Plan Administrator timely notice of the qualifying event. To be timely, you must deliver this notice of a qualifying event to the Plan Administrator at:

Plan Administrator's Name	Address	City	State	Zip

within 60 days after the qualifying event or within 60 days after the date coverage is lost under the Plan because of the event, whichever is later. **If you do not deliver this notice by the due date above, you will lose your right to elect COBRA continuation coverage.** Please refer to the summary plan descriptions for your group health plan(s) for more information about COBRA continuation coverage.

Group Health Plan Information:
Please check the group health plans (the "Plan") under which you had coverage on the day before the qualifying event:
☐ Health ☐ Dental

Covered Employee Information:
Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP

Qualified Beneficiary Information:
Please complete the information below for each person (spouse and dependent children) who lost or will lose coverage under the Plan because of the qualifying event.

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

Notice of Initial Qualifying Event:
Please check the event that occurred and give the date it occurred:

☐ DIVORCE OF THE EMPLOYEE AND SPOUSE* ☐ DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD *IF THE EVENT IS A DIVORCE, YOU MUST INCLUDE A COPY OF THE DIVORCE DECREE WITH THIS NOTICE.	DATE OF INITIAL QUALIFYING EVENT: __________ MM/DD/YYYY

SIGNATURE PRINT NAME DATE

MKT-52 (10-2004)