



# NOTIFICATION TO PLAN ADMINISTRATOR OF A COBRA QUALIFYING EVENT OR SOCIAL SECURITY DISABILITY

## ATTENTION EMPLOYEE AND/OR SPOUSE AND/OR DEPENDENT:

This form is to be completed by a covered employee, spouse or dependent to report certain events to the office of Human Resources Development (HRD) at the University of Hartford as required under provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Failure to complete and submit this form in a timely manner will result in a loss of health insurance continuation rights available under COBRA. If you have any questions regarding this form, its purpose or how to complete it, please contact HRD at (860)768-4666.

### INSTRUCTIONS

Please complete the information requested and submit this form to HRD at the address listed below. If the qualifying event is a divorce, legal separation or a child ceasing to be a dependent under the terms of the group health plan, notification must be made within 60 days of the later of (a) the date of the qualifying event or (b) the date that the qualified beneficiary would lose coverage due to the qualifying event.

Name of Company: University of Hartford

Name of Covered Employee: \_\_\_\_\_

Affected Participant: \_\_\_\_\_

Relationship to Employee: \_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent

#### Please Check One:

Divorce Date of Event: \_\_\_\_\_  
(Attach copy of signed divorce decree)

Legal Separation Date of Event: \_\_\_\_\_  
(Attach copy of signed legal separation)

Child Ceasing to be a Dependent Date of Event: \_\_\_\_\_

Social Security Disability Date of SSA Disability: \_\_\_\_\_  
(Attach copy of Social Security Disability determination, which must be submitted within 60 days from the date the SSA made the determination of disability and within the original 18 months of continuation coverage. A determination of additional eligibility for continuation coverage will be made at that time.)

\_\_\_\_\_  
Signature of Affected Participant

\_\_\_\_\_  
Date of Notification

#### Current Mailing Address of Affected Participant:

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Mail or Fax Completed Form to: Human Resources Development  
University of Hartford  
200 Bloomfield Avenue  
West Hartford, CT 06117  
Fax # (860)768-4732