BAY AREA DELIVERY DRIVERS SECURITY FUND - NOTICE OF COBRA EVENT FORM

Mailing Address: 4160 Dublin Blvd., Suite 400, Dublin, CA 94568

This form should be completed by an employee, dependent or an authorized representative to notify the Fund Administrative Office of the employee's death or divorce, a child's loss of dependent status under the Fund provisions, a determination of disability or cessation of disability, or the employee's enrollment in Medicare (Part A or Part B). This notice must be provided according to the deadlines described below. Additional information may be requested by the Fund Administrative Office. Such additional information must be provided within 15 business days of the request or your notice will be deemed incomplete and your COBRA rights will be lost. **WARNING: If your notice is late or is incomplete, COBRA Coverage may be lost.**

***Complete the following*:**

Name of Employee: _____

(the employee or former employee who was covered by the Fund):

ID# or Social Security No: _____ Telephone: (_____)_____

Address of Employee: _____

Name of qualified beneficiary(ies): _____

_____

Address of qualified beneficiary(ies) (*if different*): _____

_____

(If you need additional space to include all qualified beneficiaries or addresses, please attach another sheet of paper)

Event Description (*check one and complete*):

Unless otherwise noted, provide notice of these events within 60 days after the date of the event.

- ❑ Divorce of Employee and Spouse Date of divorce: _____
  Attach a copy of the divorce decree.
- ❑ Employee's child ceased to be an eligible dependent under the terms of the Plan because (*check one*):
  ❑ Attainment of Plan limitation age (19 or 26 for students) ❑ Loss of student status ❑ Marriage ❑ Other (*explain*): _____
  Date of event causing loss of eligibility: _____
- ❑ Death of former employee who was covered under COBRA at the time of death. Date of death: _____
  Attach a copy of the death certificate.
- ❑ Coverage under another group health plan without preexisting condition exclusions that apply to you.
  Date of coverage: _____
- ❑ Coverage of qualified beneficiary under Medicare. Date of Medicare enrollment: _____
  (*Attach a copy of the Medicare card showing the date of entitlement*).
- ❑ Disability determination by the Social Security Administration (*you must include a copy of the determination letter).*
  ❑ Determination of Disability. **Provide notice within 60 days of determination and within first 18 months of COBRA.**
  ❑ End of Disability. **Provide notice within 30 days of determination.**
  Date of SSA determination: _____

Certification, Signature, and Date:

I certify that the above information is true and correct.

I am the *(check one*): ❑ employee or former employee ❑ spouse or former spouse ❑ former dependent child ❑ other

Signature_____ Date_____

Print Name _____ Tel. No. _____

Address _____

Mail or hand-deliver completed form to address above. Oral, faxed and electronic notices are not permitted.

-For Plan Use Only-

Date Notice of COBRA Event received: _____ Date of postmark, if mailed: _____