

Note to Employer: Please photocopy this form onto your letterhead and use as necessary.

SEIU Local 1 & Participating Employers Health Trust
Cobra Coordinator – Delia Garcia
111 E. Wacker Drive, 17th Floor
Chicago, IL 60601

COBRA Phone (312) 233-8888
Fund Office Fax (312) 233-8839
Email cobra@seiu25.org

COBRA QUALIFYING EVENT NOTICE

Federal law requires employers to notify the Health Trust within thirty (30) days of any of the following events: an employee’s termination of employment, reduction of hours, retirement, death or entitlement to Medicare.

When any qualifying event occurs, complete this form and return it to the Fund Office at your earliest opportunity via mail, fax or Email, so that the participant can be offered continued coverage in the SEIU Local 1 & Participating Employers Health Trust.

_____	()	_____	_____
Employee Name	Phone	Social Security Number	
_____	_____	_____	_____
Employee Address	City	State	Zip
_____	_____	_____	_____
Building Name	Building Address	Zip	

Please indicate the actual or effective date on one of the following qualifying events:

- | | | | |
|-----------------------|-------|-------------------------|-------|
| 1. Termination Date | _____ | 5. Resignation | _____ |
| 2. Reduction of Hours | _____ | 6. Layoff | _____ |
| 3. Retirement Date | _____ | 7. Medicare Entitlement | _____ |
| 4. Date of Death | _____ | 8. Other: | _____ |

Reported by	_____	Title	_____	Phone ()	_____
	(please print)				

Employer Name	_____	Date	_____
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Fund Office:

Received: _____ Initial _____ Processed: _____