Bethany Benefit Service

P.O. Box 316560, Chicago, Illinois 60631
Fax: (773) 784-2249 | Email: bethany@covchurch.org

Notice of Qualifying Event

Dependent child ineligible, divorce or legal separation

Instructions: Fill out and return this form to Bethany Benefit Service.

This form must be received within 60 days of the date of the qualifying event (i.e. birthday, divorce date) to be eligible for COBRA continuation coverage.

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: _____ / _____ / _____

2. TYPE OF CHANGE

I request the termination of insurance for an ineligible dependent due to the following qualifying event (check one):

☐ Dependent child no longer eligible under the Plan.

Name of child _____

Child must be cancelled as my dependent due to the following reason (check one):

- ☐ Is no longer my legal dependent
- ☐ Attained age 26
- ☐ Is covered by another health insurance plan

If child's address is different than the employee's address on file, please include it below:

_____

☐ Divorce ☐ Legal separation (if legal separation causes a loss of coverage)

Note: Legal documentation required--please include with this form.

Name of spouse _____

Address of spouse _____

I am the (check one): ☐ Employee ☐ Spouse (or former spouse) ☐ Dependent child no longer eligible

3. AUTHORIZED SIGNATURE

Signature: _____ Date: _____ / _____ / _____