COVENANT BENEFITS

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Notice of Qualifying Event

Dependent child ineligible, divorce or legal separation

Instructions: Fill out and return this form to Covenant Benefits.

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

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: _____ / _____ / _____