COBRA - Notice of Qualifying Event

City of Missoula - 2000203

Name, SSN and Last known address of Qualified Beneficiary*	Date of Qualifying Event	Type of Qualifying Event**
______________________	____________	________________
______________________		
______________________		
______________________		

	Yes	No
Keep City of Missoula Insurance	☐	☐
Keep Voluntary Vision Insurance (if applicable)	☐	☐
Keep Supplemental Life Insurance (if applicable)	☐	☐

If coverage is being voluntary WAIVED by an eligible employee, please submit a signed waiver of coverage – NOT this COBRA Qualifying Event form.

***Qualified Beneficiary** is the former employee or a covered dependent of the employee or former employee, whether or not the employee is a COBRA participant.

****Qualifying Events are:**

Reduction of employee hours;
Termination of employee;
Retirement of employee;
Death of Employee;

In-eligible dependent or spouse/domestic partner;
Divorce or legal separation from spouse/domestic partner.

Please mail, fax, or email (through the City's secure server) this completed form to:

ALLEGIANCE BENEFIT PLAN MANAGEMENT
PO BOX 3018 MISSOULA, MT 59806

ATTN: Debbie Meeks

EMAIL: debbie.meeks@askallegiance.com