DMBA

NOTICE OF QUALIFYING EVENT

Deseret Healthcare Employee Benefits Plan and Deseret Healthcare Flexible Benefits Plan

INSTRUCTIONS

Use this notice when any of the following events (called qualifying events) occurs:

- A spouse covered under the Deseret Healthcare Employee Benefits Plan and the Deseret Healthcare Flexible Benefits Plan (collectively referred to herein as the "Plan") becomes divorced or legally separated from the covered employee;
- A divorce or legal separation occurs subsequent to the covered employee's anticipatory reduction or elimination of his or her spouse's coverage; or
- A child covered under the Plan ceases to be a dependent under the terms of the Plan.

The deadline for providing this notice is 60 days after the later of (1) the qualifying event and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

If your notice is late, or if it is not completed and provided to DMBA as described above, no qualified beneficiary will be offered the opportunity to elect COBRA coverage.

Return notice of qualifying event to DMBA:

Mail: DMBA
P.O. Box 45530
Salt Lake City, UT 84145

Fax: 801-578-5933

Email: enrollmenthelp@dmba.com

Your notice must be in writing (using this form) and must be mailed, faxed or emailed. Oral notice, including notice by telephone, is not acceptable. If you mail your notice, it must be postmarked on or before the deadline described above. If you fax or email your notice, it must be received at the address specified above on or before the deadline described above.

For more information about this notice, the Plan's notice procedures, and your COBRA rights and obligations, consult the summary plan descriptions for the Plan and the Plan's COBRA initial notice. You may obtain copies of these documents from DMBA.

PARTICIPANT INFORMATION & QUALIFIYING EVENT

Employee name: _____ DMBA ID Number: _____

Address: _____

Birth date: _____ Phone: _____ Email: _____

Qualifying event: ☐ Divorce ☐ Legal Separation ☐ Child no longer an eligible dependent

DIVORCE OR LEGAL SEPARATION

Spouse's name: _____

Spouse's address: _____

DMBA

Are any children loosing coverage: ☐ Yes ☐ No

Children's names: _____

Children's address: _____

Date of divorce or legal separation: _____

You must provide a copy of the decree of divorce or legal separation. If the spouse's coverage was reduced or eliminated, and later a divorce or legal separation occurred, you must provide evidence that the spouse's Plan coverage was eliminated or reduced in anticipation of the divorce or legal separation with this notice.

CHILD HAS CEASED TO BE AN ELIGIBLE DEPENDENT

Child's name: _____

Child's address:_____

Reason child has ceased to be an eligible dependent: ☐ Turned age 26 ☐ Other (explain) _____

Date of event causing child's loss of dependent eligibility: _____

SIGNATURE

Signature: _____ Date: _____

Person signing (check one): ☐ Employee ☐ Spouse or former spouse ☐ Qualified beneficiary