DMBA

NOTICE OF SECOND QUALIFYING EVENT

Deseret Healthcare Employee Benefits Plan and Deseret Healthcare Flexible Benefits Plan

INSTRUCTIONS

Use this notice if the qualified beneficiary meets both of the following conditions:

- The qualified beneficiary became entitled to COBRA coverage due to a qualifying event that was either the termination of the covered employee's employment or the reduction of the employee's hours of work; and
- Any of the following events (called second qualifying events) occurs:
  - » A spouse who is already receiving COBRA coverage becomes divorced or legally separated from the covered employee;
  - » A child who is already receiving COBRA coverage ceases to be a dependent under the terms of the Deseret Healthcare Employee Benefits Plan and the Deseret Healthcare Flexible Benefits Plan (collectively referred to herein as the "Plan"); or
  - » The covered employee dies while one or more qualified beneficiaries are already receiving COBRA coverage.

The deadline for providing this notice is 60 days after the date of the second qualifying event.

If your notice is late, or if it is not completed and provided to DMBA as described above, no extended COBRA coverage will be available to any qualified beneficiary.

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 other provisions of the Plan's COBRA initial notice and election notice. You may obtain copies of these documents from DMBA.

PARTICIPANT INFORMATION AND QUALIFYING EVENT

Employee name: ____________________ DMBA ID Number: ____________________

Address: ____

Birth date: ______________ Phone: ______________ Email: ______________

Date of first qualifying event (employment termination or reduced hours): ____________________

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

☐ Death of covered employee (provide a copy of the death certificate) date of death: ______________

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ALL QUALIFIED BENEFICIARIES

Print names of all the qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

Name	Address

DIVORCE OR LEGAL SEPARATION

Spouse's name: ______________________________

Spouse's address: ______________________________

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.

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