## Notice of Qualifying Event Form Montana Contractors' Association Health Care Trust (MCAHCT) Benefit Plan

## INSTRUCTIONS:

Refer to the Plan's COBRA Notice Procedures for instructions on the content and delivery of this Notice. If you do not have a copy of the Procedures, ask the COBRA Administrator for a copy. **Deadline: Mail or hand-deliver** this Notice within 60 days after the later of (a) the date of the Event described in Section 2 below or (b) the date Plan coverage ends due to the Event described in Section 2. **Address: Mail** or hand-deliver this Notice to the COBRA Administrator:

Allegiance COBRA Services, Inc. 2806 S. Garfield

Missoula, MT 59806-3018

P. O. Box 3018

<ol> <li>Identify the Employee</li> </ol>	
Print Name of Employee:	Address of Employee:
2. Event Description (Check Box A or	B and complete)
☐A. Employee and spouse: ☐ divorced ☐ legally s	separated Date of divorce/legal separation:
Print name of spouse:	Address of spouse:
☐B. Employee's child ceased to be an eligible depe	endent under the Plan
	one):   Attained age 26   Parent's divorce from Employee (step-child on from Employee (step-child loses dependent status)   Married   Married
Print name of child:	Date child ceased to be dependent (for example, date attained age, date married):
Address of child: ☐ Same as employee's address	□ Different address (provide address below)
3. Certification, Signature, Date and T	elephone Number
I certify that the above information is true and correct	
I am the (check one): ☐ Employee ☐ Spouse or for	rmer spouse ☐ Former dependent child ☐ Other (explain below)
Signature F	Print Name
Date	Felephone Number
	Office Use Only
	201
Was Notice timely? ☐ Yes ☐ No If "No", retain envelope. Has envelope been retained? ☐ Yes ☐ No	