

Notice of Second 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 date of the Second Qualifying Event identified in Section 3 below. **Address:** Mail or hand-deliver this Notice to the COBRA Administrator:

Allegiance COBRA Services, Inc.
2806 S. Garfield
P. O. Box 3018
Missoula, MT 59806-3018

1. Identify the Employee

Print Name of Employee:	Address of Employee:
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2. Identify Initial Qualifying Event

Termination of Covered Employee's Employment Reduction in Hours of Covered Employee's Employment

3. Identify Second Qualifying Event (Check Box A, B or C and complete)

<input type="checkbox"/> A. Employee and spouse: <input type="checkbox"/> divorced <input type="checkbox"/> legally separated	Date of divorce/legal separation:
<input type="checkbox"/> B. Employee's child ceased to be an eligible dependent under the Plan	Reason child ceased to be eligible dependent (check one): <input type="checkbox"/> Lost dependent status on 26 th birthday <input type="checkbox"/> Parent's divorce from Employee (step-child loses dependent status) <input type="checkbox"/> Parent's legal separation from Employee (step-child loses dependent status) <input type="checkbox"/> Married <input type="checkbox"/> Other (explain):

Date child ceased to be dependent (for example, date attained limiting age):

<input type="checkbox"/> C. Death of Employee	Date of employee's death
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4. Identify the Affected Qualified Beneficiary(y)(ies) [Spouse or Child(ren) who are currently receiving COBRA coverage.]

Print name of spouse:	Address: <input type="checkbox"/> Same as employee's address <input type="checkbox"/> Different address (provide address)
Print name of child	Address: <input type="checkbox"/> Same as employee's address <input type="checkbox"/> Different address (provide address)
Print name of child	Address: <input type="checkbox"/> Same as employee's address <input type="checkbox"/> Different address (provide address)
Print name of child	Address: <input type="checkbox"/> Same as employee's address <input type="checkbox"/> Different address (provide address)

5. Certification, Signature and Date

I certify that the above information is true and correct.

I am the (check one): Employee Spouse or former spouse Former dependent child
Other (explain below)

Signature	Print Name	Date
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For Office Use Only

Date of Postmark: _____, 201_____

Was Notice timely? Yes No If "No" retain envelope. Has envelope been retained? Yes No