

**MONTANA UNIVERSITY SYSTEM**  
**COBRA QUALIFYING EVENT FORM**  
**For Employer Use**

**Campus:** \_\_\_\_\_ **Group No:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Please Check box for Qualifying Event**

**Employee losing coverage because of:**

- |   |  |
|---|--|
| <input type="checkbox"/> Reduction in work hour's | <input type="checkbox"/> Layoff                                    |
| <input type="checkbox"/> Voluntary Resignation    | <input type="checkbox"/> Discharge other than for gross misconduct |

**Spouse/dependent(s) losing coverage because of:**

- |  |  |
|--|--|
| <input type="checkbox"/> Surviving spouse or children of a deceased employee | <input type="checkbox"/> Legal Separation  |
| <input type="checkbox"/> Divorce   | <input type="checkbox"/> Dependent no longer eligible as a dependent under the health plan |

**Dependent(s):**

**Address: (If different from the employee)**

_____	_____
_____	_____
_____	_____
_____	_____

**Qualifying Event Date:** \_\_\_\_\_

**Loss of Coverage Date:** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RETURN TO: ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC**  
**PO BOX 4786**  
**MISSOULA, MT 59806**  
**FAX 406-523-3187**