NOTICE OF A COBRA-RELATED EVENT

Attn: COBRA COORDINATOR
Hawaii Employer-Union Health Benefits Trust Fund
PO Box 2121
Honolulu, HI 96805-2121
Fax: (808) 586-2161

The undersigned is hereby providing notice to the COBRA COORDINATOR of the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) of the occurrence of a qualifying event or other COBRA-related event. Notice is being provided in order to preserve the COBRA continuation coverage rights of the undersigned and all related qualified beneficiaries/covered dependents who are or were covered under the EUTF's group health plan(s).

The following COBRA-related event occurred on: _____

☐ Divorce of the covered employee and covered spouse	☐ A 2nd qualifying event occurred after a qualified beneficiary has become entitled to COBRA with a maximum coverage period of 18 months (or, if applicable, 29 months); the 2nd qualifying event was:
☐ A covered dependent child ceased to be a dependent under the terms of the EUTF's plan(s)	☐ After electing COBRA, a qualified beneficiary became entitled to coverage under Medicare (Part A, B or both)
☐ After electing COBRA, a qualified beneficiary became covered under another group health plan, which does not limit or exclude a pre-existing health condition of the qualified beneficiary.	☐ The Social Security Administration determined that a qualified beneficiary previously determined to be disabled is no longer disabled.
☐ The Social Security Administration determined that a qualified beneficiary with a maximum COBRA coverage period of 18 months was totally disabled at any time during the first 60 days of COBRA coverage.	

The following individuals/qualified beneficiaries covered under the EUTF's plan(s) are affected by this event:

_____

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Documentation of the event including the date of its occurrence is attached. Please take the appropriate steps to enable the qualified beneficiaries affected by this event **to exercise their COBRA continuation coverage rights**.

_____ _____
Signature Date

_____ _____
Name of Covered Employee/Qualified Beneficiary Telephone Number

_____ _____
Mailing Address City, State, Zip Code

Keep a copy of the completed form for your records