NOTICE OF QUALIFYING EVENT
Required by the Consolidated Omnibus Budget reconciliation Act of 1985
U.S. Public Law 99-272

This form is notice under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 of a change in my employment status or a dependent's eligibility. This form must be sent to UnitedHealthcare **within 60 days** from the date of the event to preserve your right to continue coverage. **COBRA coverage must be purchased from the day after the group benefits ends.**

EMPLOYEE'S NAME	EMPLOYEE'S DATE OF BIRTH	EMPLOYEE'S SOCIAL SECURITY NUMBER
EMPLOYEE'S RAILROAD	**EMPLOYEE TELEPHONE NUMBER**	IS THE EMPLOYEE COVERED BY A HOSPITAL ASSOCIATION? ☐ **Yes** ☐ **No**
NAME OF UNION	POLICY NUMBER	
EVENT CAUSING TERMINATION OF COVERAGE	DATE OF EVENT (MM-DD-YY	

LIST ALL INDIVIDUALS LOSING COVERAGE (USE ANOTHER SHEET OF PAPER IF NECESSARY)

FULL NAME	SOCIAL SECURITY NUMBER	MAILING ADDRESS (STREET, CITY, State, Zip Code)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE

Coverage Request: **Subject to eligibility verification	**Medical**	**Dental**	**Vision**
Employee	☐	☐	☐
Spouse or Ex-Spouse	☐	☐	☐
All Children	☐	☐	☐
Dependent Children not Eligible	☐	☐	☐

SIGNATURE _____ DATE _____

Mail completed form to:
UnitedHealthcare
Railroad Administration (COBRA)
PO Box 150453
Hartford, CT 06115-0453
800-842-5252

Or Fax to:
860-702-5295

If coverage request is not completed, UnitedHealthcare will send an election form within 14 days from the receipt of this notice

IMPORTANT ANNOUNCEMENT CONCERNING YOUR HEALTH, DENTAL AND / OR VISION BENEFITS

Federal law (COBRA) gives certain individuals the right to continue Plan benefits at their own expense when those benefits would otherwise terminate because of one or another of the reasons listed in the law.

The employer will notify UnitedHealthcare if an employee ceases to render the "Requisite Amount of Compensated Service." However, employees must notify the Plan administrator (within 60 days after) when a divorce occurs or a child no longer meets the definition of a dependent. Use the form on the reverse side of this page to report such an event.

To obtain more information regarding your rights under this law, please refer to the section labeled "Optional Continuation Coverage under COBRA" in your Health Summary Plan Description. This law applies to:

The Railroad Employees National Health and Welfare Plan

The Railroad Employees National Railway Carriers and United Transportation Union (NRC/UTU) Health and Welfare Plan

The Railroad Employees National Dental Plan administered by the Aetna Life Insurance Company under Group Policy GP-12000

The Railroad Employees National Vision Plan administered by Vision Service Plan

This is NOT a notice that your benefits under any Plan are terminating.

ONLY THE COVERAGE(S) YOU HAVE WHEN THE EVENT THAT TRIGGERS YOUR RIGHT TO CONTINUE BENEFITS CAN BE CONTINUED.