



Your Future — Our Focus

## Chicago Regional Council of Carpenters Welfare Fund

### Instructions for Completing the COBRA Notice to Administrator Form

**1. Who must submit this form?**

- a) Dependents applying for continuation of coverage under COBRA who lose coverage as a result of a qualifying event such as a legal separation, divorce or a child losing dependent status.
- b) An individual, currently receiving continuation of coverage under COBRA, applying for an extension of due to an employee's death, divorce or child losing dependent status occurring within the initial 18-month COBRA coverage period.
- c) An individual applying for the 11 month disability extension of their COBRA coverage when the Social Security Administration determines a family member to be disabled. The disability would have to start at some time before the 60<sup>th</sup> day of COBRA continuation of coverage and must last at least until the end of the 18-month period of COBRA continuation of coverage.

**2. When am I required to submit this notice?** This notice must be submitted to the Fund Office within 60 days of a qualifying event such as a legal separation, divorce, a child losing dependent status or the receipt of the Social Security Administration disability Award letter. If a covered individual does not notify this Fund within 60 days of such an event, he/she will forfeit the right to continuation of coverage under COBRA or the applicable extension.

**3. What documentation is required to be submitted with this Form?** Based on your qualifying event, you are required to submit copies of your Decree of Divorce, Legal Separation, Death Certificate or Social Security Disability Award letter.

**4. Submit the completed COBRA Notice to Administrator Form and required documentation to:**

Fax: Chicago Regional Council of Carpenters Welfare Fund  
Attn: COBRA Department  
Fax Number: 312-951-1515  
(Note: Write the Participant's name and ID number on each page)

Mail: Chicago Regional Council of Carpenters Welfare Fund  
Attn: COBRA Department  
12 East Erie Street - 7<sup>th</sup> floor  
Chicago, IL 60611

**5. What happens next?** The Fund Office will notify you within 14 days of receipt of your notice of your eligibility to elect continuation of coverage under COBRA. Should you qualify, you will be sent a COBRA continuation of coverage election form. You will have up to 60 days to complete and return the COBRA continuation of coverage election form. The Fund Office will also advise you in writing if your extension of coverage request is approved.

**COBRA Notice to Administrator Form**

Re: **COBRA Notice to Administrator**

To: Fund Administrator c/o COBRA Department  
Chicago Regional Council of Carpenters Welfare Fund  
12 E. Erie  
Chicago, IL 60611

Dear \_\_\_\_\_:

This letter is to inform you of the following event(s) (check which one(s) apply and fill out and/or attach the requested information):

My spouse and I have/will become divorced or legally separated.

Date of divorce or legal separation: \_\_\_\_\_

Names of covered employee (participant) and all qualified beneficiaries (spouse and other dependents): \_\_\_\_\_

**Please provide a copy of your Decree of Divorce or Legal Separation.**

My child will/has cease[d] to be covered under the Plan as a dependent child of a participant.

Date child has/will no longer be considered a dependent: \_\_\_\_\_

Name of child: \_\_\_\_\_

Reason why child is no longer a dependent: \_\_\_\_\_

\_\_\_\_\_

I myself and/or my dependents, who are currently receiving COBRA, have a second qualifying event due to an employee's death, divorce or child losing dependent status.

State the First Qualifying Event that applies: \_\_\_\_\_

Date of the First Qualifying Event: \_\_\_\_\_

Names of covered employee (participant) and all qualified beneficiaries (spouse and other dependents): \_\_\_\_\_

State the Second Qualifying event that applies: \_\_\_\_\_

Date of the Second Qualifying Event: \_\_\_\_\_

**Please provide a copy of the Death Certificate or Divorce Decree.**

- I myself and/or my dependent have been determined to be disabled by the Social Security Administration. The Social Security Administration subsequently has not determined that I am no longer disabled.

State the Qualifying Event that applies: \_\_\_\_\_

Date of the Qualifying Event: \_\_\_\_\_

State the date of the Social Security determination: \_\_\_\_\_

Names of covered employee (participant) and all qualified beneficiaries (spouse and other dependents): \_\_\_\_\_

**Please provide a copy of the Social Security Determination.**

- I myself and/or my dependent have been determined to be no longer disabled by the Social Security Administration.

State the Qualifying Event that applies: \_\_\_\_\_

Date of the Qualifying Event: \_\_\_\_\_

State the date of the Social Security determination \_\_\_\_\_

Names of covered employee (participant) and all qualified beneficiaries (spouse and other dependents): \_\_\_\_\_

**Please provide a copy of the Social Security Determination.**

- I myself and/or my dependents who are currently receiving COBRA, has/have become, after electing COBRA, covered under other group health plan coverage or entitled to Medicare.

State the Qualifying Event that applies: \_\_\_\_\_

Date of the Qualifying Event: \_\_\_\_\_

Name and Address of individual who obtained other coverage or Medicare entitlement:  
\_\_\_\_\_  
\_\_\_\_\_

Effective Date of other coverage or Medicare entitlement:  
\_\_\_\_\_

Did any preexisting condition exclusion apply to the individual and, if so, the date that these were exhausted or satisfied:

\_\_\_\_\_  
\_\_\_\_\_

**Please provide a copy of the insurance card, application for coverage or Medicare card showing the date of Medicare entitlement.**

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My current address and that of my dependents is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Certification:**

I, \_\_\_\_\_ [print name], certify that the above information contained in this Notice To Administrator is accurate.

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

\_\_\_\_\_  
Participant's Name (the Carpenter)

\_\_\_\_\_  
Participant's ID # (located on your BCBS ID Card)

**Sincerely,**

\_\_\_\_\_  
**[Name of Participant or Qualified Beneficiary]**

\_\_\_\_\_  
**Date**