DAKOTA WESLEYAN UNIVERSITY

EMPLOYEE/QUALIFIED BENEFICIARY NOTICE OF A QUALIFYING EVENT

I _____ hereby notify Dakota Wesleyan University's plan administrator of a qualifying event that is a:

_____ Divorce or legal separation
- A copy of the decree must be attached

_____ Loss of a dependent child's eligibility for coverage as a dependent (as defined by plan terms)
- age 29 or over and not a full time student
- a dependent child who marries

_____ Social Security Administration determination of a disability
- the determination date must be prior to the 60th day of COBRA
- a copy of the determination must be attached
- you must notify us within 30 days of the loss of this determination

The qualifying event or disability determination occurred on _____. I realize this notice must be sent to the plan administrator (Director of Human Resources) within 60 days of this event.

The individual(s) affected by the above event is/are:

_____ relationship _____

_____ relationship _____

_____ relationship _____

_____ relationship _____

_____ _____ _____
(employee signature) (date) (phone number)

_____ _____ _____ _____
(address) (city) (state) (zip code)

Address and phone number of the affected individual (if different than the above address)

_____

All of the above information must be given or the continuation of health insurance may be denied. As an employee or qualified beneficiary, you are advised to keep a copy of this notice for your records.