Washington Teamsters Welfare Trust Fund
c/o Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102-3393
Phone (206) 726-3277 or (800) 458-3053 Fax (206) 926-2699

EMPLOYER COBRA NOTICE TO ADMINISTRATOR (SPOUSE / DEPENDENT)

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires the employer or a family member to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan, within 60 days of the event or the date on which coverage would end under the plan because of the event, whichever is later.

INSTRUCTIONS: If a covered employee, spouse or dependent informs you that one of the Qualifying Events listed below has occurred, please complete this form and send it to Northwest Administrators at the address shown above.

Employer/Institution Name:	Telephone Number:
Date of Qualifying Event:	**Date Active Coverage Terminates:**

COBRA Qualifying Event:
☐ Divorce
☐ Dependent Lost Eligibility under the Plan as a "Dependent Child"

Name of Employee: ______________________________

Social Security No.: ______________________________

Name of Spouse/Dependent: ______________________________

Current Address: ______________________________

City: ____________________ State: __________ Zip Code: ______________

Telephone No.: ____________________ Social Security No.: ______________

SIGNATURE OF EMPLOYER REPRESENTATIVE

______________________	______________________	______________
(Signature)	(Print Name)	(Date)

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EMPLOYER COBRA NOTICE TO ADMINISTRATOR (EMPLOYEE)

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires the employer to notify the Plan Administrator of the death, termination of employment or reduction in hours (below the minimum required for eligibility) or Medicare entitlement of a covered employee.

INSTRUCTIONS: When a Qualifying Event occurs, please complete this form and send it to Northwest Administrators at the address shown above.

Employer/Institution Name:	**Telephone Number:**
Date of Qualifying Event:	**Date Active Coverage Terminates:**

COBRA Qualifying Event:

- ☐ Termination of Employment
- ☐ Death of the Employee
- ☐ Involuntary Termination
- ☐ Reduction in Hours (Below the minimum required for eligibility)
- ☐ Medicare Entitlement

Name of Employee: ______________________

Current Address: ______________________

City: ______________ State: ________ Zip Code: ____________

Telephone No.: ______________ Social Security No.: ____________

Names of Employee's Spouse and Dependents (if covered):

Spouse: ______________________

Dependent: ______________________

Dependent: ______________________

Dependent: ______________________

SIGNATURE OF EMPLOYER REPRESENTATIVE

______________________ ______________________ ____________

(Signature) (Print Name) (Date)

(REV 2015)