NATIONAL IAM
BENEFIT TRUST FUND
Better Benefits · Better Life

1300 Connecticut Avenue, NW, Suite 300
Washington, DC 20036-1703
Phone: 800-457-3481 • Fax: 202-728-0585
Website: www.iambtf.org

EMPLOYER NOTICE TO PLAN ADMINISTRATOR OF COBRA QUALIFYING EVENT

(***Instructions:*** ***The Employer must provide the information requested in each blank below and then forward the completed notice to the Fund Office. If you have any questions about how this form should be completed, please contact the Fund Office.)***

_____
(date of notice)

Dear Fund Office:

This notice is to inform you that: _____ , _____
(name of employee/former employee) *(employee SSN)*

an employee/former employee of: _____
(name of employer)

has experienced a COBRA "qualifying event" under section 606(a)(2) of ERISA that is a:

(check appropriate box below)

- ☐ **Death of the Employee**
- ☐ **Medicare Eligibility of Employee**
- ☐ **Termination or reduction in hours of the Employee**
- ☐ **Retirement**

_____ **was a Participant in the National IAM Benefit Trust Fund.**
(name of employee/former employee)

Coverage under the Plan will be lost on: _____
(date of loss of coverage)

Signed: _____ _____
(signature of employer representative) *(title of employer representative)*

In accordance with our obligations under sections 606(a)(2) and (b) of ERISA, this notice is being provided within 30 days of the qualifying event. As a result of this qualifying event, the Participant and his/her qualified spouse and dependents will be eligible to elect COBRA continuation coverage at this time. Please forward the Participant, his/her Spouse, and his/her qualified dependents the COBRA Election Notice and Election Forms within 14 days of receipt of this letter.