NOTICE OF SECOND QUALIFYING EVENT FORM

_____
Employer Name/Plan Sponsor

When to Use This Form:

Use this form when any of the following events (second qualifying events) occurs:

- A spouse who is receiving COBRA coverage becomes divorced or legally separated from the covered employee;
- A child who is receiving COBRA coverage ceases to be a dependent under the terms of the Plan; or
- The covered employee dies while one of more qualified beneficiaries are receiving COBRA coverage.

Deadline:

The deadline for providing this Notice of Second Qualifying Event is 60 days after the later of: (1) the date of the second qualifying event; and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

How to Provide Notice of Second qualifying Event:

You must mail or hand deliver this notice to:

Tri-Star Systems
Attn: COBRA
16401 Swingley Ridge Road, Suite 250
Chesterfield, MO 63017

Your notice must be in writing (using this form) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

> **Warning: If your notice is late, or if it is not completed and provided to Tri-Star Systems as described above, no extended COBRA coverage will be available to any qualified beneficiary.**

For more information about this form, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's summary plan description and the Plan's COBRA initial notice and election notice (for 18-month qualifying events). (You may obtain copies of these documents from your former employer.)

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Employer Name/Plan Sponsor

Complete This Portion:

Identify the Employee Who Was Covered Under the Plan:

Print name of employee:_____

Address of employee: _____

_____

Identify Initial Qualifying Event (the event that started your COBRA coverage) (Check one and omplete):

❑ Termination of employment Reduction of Hours

Date of initial qualifying event: _____/_____/_____

Identify All Qualified Beneficiaries:

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

_____

_____

Address of each qualified beneficiary: same as employee's address different address(provide address)

_____

Identify Second Qualifying Event (Check one and complete):

Second Qualifying Event—Employee and spouse: (check one) divorced legally separated

Print name of spouse: _____

Address of spouse: _____

_____

Date of divorce or legal separation: ____/____/_____

You must provide a copy of the decree of divorce or legal separation. Is a copy enclosed? • Yes • No

Second Qualifying Event—Employee's child ceased to be an eligible dependent under the Plan

Print name of child: _____

Address of child: same as employee's address different address (provide address)

_____

_____

Reason child ceased to be eligible dependent (check one): attained age ___ lost student status married

other (explain) _____

Date of event causing loss of dependent eligibility: ____/____/_____

Second qualifying event—Death of covered employee Date of employee's death: ____/____/_____

Certification, Signature and Date: I certify that the above information is true and correct.

I am the (check one): employee or former employee spouse or former spouse former dependent child

other (explain) _____

_____ _____
Signature Date

_____
Print Name

_____
Address

_____
Address

(_____) _____--_____
Telephone Number