

**NOTICE OF "QUALIFYING EVENT"
TERMINATION OF HEALTH INSURANCE UNDER THE
IADA INSURANCE TRUST**

The following person will lose health insurance coverage under the IADA Insurance Trust and may be entitled to elect continuation coverage.

1. Name:
2. Name of covered employee, if different from (1):
3. Social Security Number:
4. Home Address:
5. If this person has family coverage, how many others (spouse and/or children) are covered under the employee's policy besides the employee? _____ (Number)
6. Does this person have a spouse or dependent child(ren) covered under the IADA Insurance Trust who lives at a different address? ____Yes____No. If yes, give the name(s) and address(es):

7. Reason for loss of coverage (check one or more):
Notify IADA within 30 days of the event

_____ Quit Employment	Date:
_____ Fired from Employment	Date:
_____ Retired	Date:
_____ Hours Cut to Below 30 per Week	Date:
_____ Death of Covered Employee	Date:
_____ Approved Leave of Absence	Date:
_____ Laid Off	Date:
_____ Divorce from Covered Employee (Dependent's Birth Date)	Date:
_____ Loss of Dependent Status (Please call IADA regarding eligibility) Dependent's Birth Date:	Date:

Signed: _____ Date: _____
Dealer Representative's Signature

Name of Dealership: _____

Mail to: IADA Insurance Trust "COBRA"
1111 Office Park Rd.
West Des Moines, IA 50265
Fax: (515) 224-2978