

**NOTICE OF "QUALIFYING EVENT"
TERMINATION OF HEALTH and/or DENTAL INSURANCE
IADA SERVICES INC**

The following person will lose health insurance and/or dental coverage and may be entitled to elect continuation coverage.

TYPE OF COVERAGE: EE ___ EE/SP ___ EE/CH ___ FAMILY ___
IF EMPLOYER HAD MORE THAN 1 Plan which plan was EE on: _____
IF APPLICABLE—DENTAL: _____ **TYPE OF COVERAGE:** _____

1. Name: _____ **EMPLOYMENT DATE:** _____
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 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
Reason: _____ | Date: _____ |
| Dependent's Birth Date: | |

Signed: _____ Date: _____
Dealer Representative's Signature

Name of Dealership: _____

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