LOS ANGELES MACHINIST BENEFIT TRUST
COBRA EVENT NOTIFICATION LETTER

Purpose of this Form

The attached form is the means by which a Trust participant can notify the Administrative Office of a COBRA qualifying event. This form should also be used to report a Social Security Administration determination of total disability or when the Social Security Administration has determined that a COBRA participant is no longer totally disabled.

It is <u>not</u> necessary for you to complete this form if the qualifying event is termination of employment or a reduction in hours of employment. Your employer will notify the Administrative Office of those events.

Where to Submit the Completed Form

This form should be completed and mailed or delivered to the Administrative Office at the following address:

Los Angeles Machinist Benefit Trust
6801 East Washington Blvd.
City of Commerce, CA 90040

Deadline for Submission of the Completed Form

If written notice is not provided to the Administrative Office within the applicable time limit specified below, those whose coverage under the Trust is terminating will not be entitled to COBRA coverage.

Your completed form must be mailed or delivered to the Administrative Office **no later than 60 days** after the latest of the following dates:

- the date of the qualifying event,
- the date coverage would be lost under the Plan as a result of the qualifying event, or
- the date you are informed (through the furnishing of a Summary Plan Description or initial COBRA notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so.

If you are providing notice of a Social Security Administration determination of total disability, your completed form must be mailed or delivered to the Administrative Office **no later than 60 days** after the latest of the following dates:

- the date of the disability determination by the Social Security Administration,
- the date coverage would be lost under the Plan as a result of the qualifying event,
- the date you are informed (through the furnishing of a Summary Plan Description or initial COBRA notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so, or

- the end of the first 18 months of COBRA coverage.

If you are providing notice of a Social Security Administration determination that you or your dependent are no longer totally disabled, your completed form must be mailed or delivered to the Administrative **Office no later than 30 days** after the latest of the following dates:

- the date of the determination by the Social Security Administration that you or your dependent are no longer totally disabled, or
- the date you are informed (through the furnishing of a Summary Plan Description or initial COBRA notice) of your responsibility to provide notice to the Administrative Office and the procedures for doing so.

Who Should Complete this Form

This form may be completed by you, your dependent or any representative acting on behalf of you or your dependents.

A completed form from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

LOS ANGELES MACHINIST BENEFIT TRUST
COBRA EVENT NOTIFICATION FORM

Please print clearly

Employee Name _____
First MI Last

Send COBRA Election
Material to _____
Street or Box # City State ZIP

Type of Event (check appropriate box and complete any requested information)

- ☐ Divorce or legal separation, date of final decree ____/____/____
- ☐ Child(ren) no longer meets Plan definition of Dependent, date of event ____/____/____
  Name of ineligible child(ren)_____
- ☐ Death of the Employee, date of death ____/____/____ (note that COBRA rules do not require you to give notice of employee death to the Administrative Office but you are encouraged to do so)
- ☐ Social Security Administration determination of total disability – a copy of the determination must accompany this form
- ☐ Social Security Administration determination that the previously totally disabled person is no longer totally disabled – a copy of the determination must accompany this form

Is this a second qualifying event? ____ No ____ Yes

Name of person who completed this form _____

Relationship to employee_____ Your Telephone # (____)_____

_____ _____
Signature Date

Mail this completed form with any required documents (by the deadline stated in the letter) to:

Los Angeles Machinist Benefit Trust
6801 East Washington Blvd.
City of Commerce, CA 90040

Questions? Please call the Administrative Office at:

323-278-7030 or 800-499-8121