MONTANAVEBA
HEALTH REIMBURSEMENT ACCOUNT

Notice to Third-party Administrator of COBRA Qualifying Event

SECTION 1: EMPLOYER INFORMATION

Please print clearly.

Employer Name: _____ Date: _____

SECTION 2. EMPLOYEE INFORMATION

Employee Name: _____ Employee SSN: _____

Employee Address: _____
Street Address City State Zip

SECTION 3. QUALIFYING COBRA EVENT

- ☐ Voluntary Termination of Employment — Date of Termination: _____
- ☐ Involuntary Termination of Employment (other than gross misconduct)
- ☐ Reduction of Hours Worked
- ☐ Death of Employee

If the Employee is married and/or has dependent children, please provide their first and last names and dates of birth below. If you need additional room, please attach a separate piece of paper.

Spouse Name: _____ DOB: _____

Dependent Name: _____ DOB: _____

Dependent Name: _____ DOB: _____

Dependent Name: _____ DOB: _____

Dependent Name: _____ DOB: _____

Please mail completed form to:

Montana HRA Third-party Administrator
REHN & ASSOCIATES
P.O. Box 5433
Spokane, WA 99205-0433
(509) 534-0600 or 1-800-VEBA101 (832-2101)
(509) 535-7883 Fax
montana@rehnonline.com