ADVANTAGE HEALTH PLANS TRUST
THE KEMPTON COMPANY, ADMINISTRATOR

EMPLOYER NOTICE OF QUALIFYING EVENT
CONTINUATION OF COVERAGE

TO: The Kempton Company, Plan Administrator

FROM: _____
(*Employer*)

RE: _____ _____
(*Name of Employee, Retiree or Director*) *S.S. Number*

_____
(*Address*) (*City*) (*State*) (*Zip*)

_____
(Last Date of Full-Time Employment or Date of Qualifying Event)

You are hereby notified that a Qualifying Event has occurred which obligates you to provide notice to Qualifying Beneficiaries of their rights to elect continuation of coverage under the Plan. Coverage for the above referenced person terminates on the _____ day of, _____20____ (*enter last day of month for which premium has been paid*). Coverage for the participant ends at the end of the month in which the Qualifying Event occurs.

The following Qualifying Event has occurred:

- ❑ Death of Employee, Director or Retiree.
- ❑ Termination of employment. ☐ Please check if involuntary termination.
- ❑ Termination of directorship.
- ❑ Reduction of employee's work hours.
- ❑ Expiration of 90 day leave of absence
- ❑ Employee divorce or legal separation.
- ❑ Dependent child has ceased to be an eligible dependent

The following are the names of the Qualified Beneficiaries and their addresses. List spouse and dependent children who were beneficiaries under the Plan on the day before the Qualifying Event. A separate address must be provided for dependents if they do not reside with the Employee, Director, or Retiree.

Name: _____ _____
S.S. Number

Address: _____

Name: _____ _____
S.S. Number

Address: _____

Prepared by: _____

Date: _____