

OPERATING ENGINEERS HEALTH AND WELFARE FUND

**NOTICE OF QUALIFYING EVENT FROM
EMPLOYEE OR OTHER QUALIFIED BENEFICIARY**

DATE: _____

TO: Operating Engineers Health & Welfare Fund Office
PO Box 7063, Pasadena, CA 91109

RE: _____
Name of Member Covered by the Plan

Social Security Number

This is to inform you of an event that qualifies me and/or my dependents for continuation of benefits coverage.

Date of the event: _____

Nature of the event (check one):

- (a) _____ Divorce
- (b) _____ A dependent child has ceased to be a dependent under the plan.

If you checked “(a) Divorce”, please state the date of the court order and county in which the court is located.



The person(s) losing coverage under this plan were:

(1) Name _____ Relationship to member: _____

Address: _____

(2) Name _____ Relationship to member: _____

Address: _____

(3) Name _____ Relationship to member: _____

Address: _____

This notice must be postmarked or delivered to the Operating Engineers Health & Welfare Fund within **60 days** after the later of:

- 1) the date of the qualifying event described above (for example, date of the divorce), or
- 2) the date coverage would be lost because of the qualifying event.