COBRA ADDRESS NOTIFICATION FORM

To the covered employee and plan participants:

It is important that you keep the Mesquite ISD Benefits Office informed of your current address so that all covered individuals under the plan receive timely information about plan benefits and group plan continuation coverage rights. So this form is to be used by you for two purposes:

SECTION 1: NOTIFICATION OF ADDRESS CHANGE

Plan information is sent to the address you have provided to the Mesquite ISD Benefits Office. Should you move, please complete Section 1 and send the form to the address listed below.

SECTION 2: NOTIFICATION OF COVERED DEPENDENT ADDRESS

When coverage under the group plan begins, or should you experience a COBRA qualifying event in the future, the plan administrator is required to send you information concerning your plan continuation rights. If, upon receiving such a notice, you have a covered dependent whose legal residence is not yours (dependent child covered by court order, living with an ex-spouse, etc.), you are required to provide the plan with a current address so an initial or election notice can be sent to them as well. Please complete Section 2 for this purpose and send to the address listed below.

You should make a copy of this form prior to mailing and you should call the Mesquite ISD Benefits Office within 10 days to ensure the information has been received.

Should you have any questions, please call 972-882-7359. Thank you for your assistance.

SECTION 1: NOTIFICATION OF ADDRESS CHANGE

Name of Employee: _____________________________________________________________
New Address: __________________________________________________________________
City, State, Zip: _______________________________________________________________

SECTION 2: NOTIFICATION OF COVERED DEPENDENT ADDRESS

1. Name of covered dependent: ________________________________________________
   Name of guardian, ex-spouse, etc.:____________________________________________
   Street address: ______________________________________________________________
   City, State, Zip: _____________________________________________________________

2. Name of covered dependent:
   Name of guardian, ex-spouse, etc.:____________________________________________
   Street address: ______________________________________________________________
   City, State, Zip: _____________________________________________________________

_________________________________________       __________________________________
Signature of Reportee                                                        Date

MAIL COMPLETED FORM TO: Mesquite ISD Benefits Office
                         3819 Towne Crossing
                         Mesquite, TX  75150