

NOTICE OF DISABILITY FORM

Welfare Benefit Plan ("Plan")

This form is for you to use to provide notice of disability for COBRA purposes. For more information about this form, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's Summary Plan Description and the Plan's COBRA election notice. (You may obtain copies of the Summary Plan Description and election notice from the Employer.)

When to Use This Form: Use this form when the Social Security Administration has determined that a qualified beneficiary was disabled on any day of the first 60 days of COBRA continuation coverage due to a qualifying event that was the covered employee's termination of employment or reduction of hours. (Note: If the Social Security Administration made the disability determination before the covered employee's termination of employment or reduction of hours, you still may use this form to report the earlier disability determination, so long as the qualified beneficiary remains disabled and you provide this Notice of Disability by the deadline described below.)

Deadline: The deadline for providing this Notice of Disability is 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage for the benefit(s) under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability also must be provided before the end of the initial (18-month) period of COBRA continuation coverage.

Notice Procedures: You must follow the Notice Procedures for Notice of Disability found in the Summary Plan Description.

Warning: If your notice is late, or if it is not completed and provided to the Employer as described in the Notice Procedures for Notice of Disability appearing in the Summary Plan Description, no extended COBRA coverage will be available to any qualified beneficiary.

Complete This Portion:

1. Identify the Covered Employee (the employee or former employee who is or was covered for the benefit(s) under the Plan):

Print name of employee: _____

Address of employee: _____

List Employer providing benefits: _____

2. Identify Initial Qualifying Event (the event that started your COBRA coverage) (*check one and complete*):

Termination of employment Reduction of hours

Date of initial qualifying event: _____

3. Identify All Qualified Beneficiaries:

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

Address of each qualified beneficiary (*check one*): same as employee's address different address (*note name and provide address*): _____

4. Identify Disabled Qualified Beneficiary:

Print name of disabled qualified beneficiary: _____

Address of disabled qualified beneficiary (check one): same as employee's address different address (note name and provide address): _____

5. Social Security Administration's Determination of Disability:

Date of Social Security Administration's determination: _____

A copy of the Social Security Administration's determination must be enclosed with this notice. Enclosed

Date that disabled qualified beneficiary became disabled (according to Social Security Administration determination): _____

Has the Social Security Administration subsequently determined that the qualified beneficiary is no longer disabled?
 Yes No

6. Certification, Signature, and Date: I certify that the above information is true and correct.

I am the (check one): employee or former employee spouse or former spouse disabled qualified beneficiary
 other (explain): _____

Signature: _____

Date: _____

Print Name: _____

Telephone Number: _____

Address: _____

Where to send the completed Notice of Disability Form: You must mail or hand deliver this notice to:

Human Resources Department

Address: _____

If no Employer address is listed above, use the Employer address in the Summary Plan Description.

You may fax this notice if a fax number is provided: Fax Number: _____

This contact information may change from time to time. The most recent contact information and other important COBRA information will be included in the Plan's most recent Summary Plan Description (if you do not have a copy, you may request one from the Employer).

For Plan Use Only:

Date Notice of Disability received: _____ Date of postmark, if mailed: _____

Social Security Administration determination of disability enclosed? Yes No

Disclaimer: This material is copyrighted material protected by U.S. copyright law. All rights are reserved. Any reproduction, distribution, or modification of these materials without the express written consent of the copyright owner is strictly prohibited.