

**NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT,
OR CESSATION OF DISABILITY FORM**
Welfare Benefit Plan ("Plan")

This form is for you to use to provide notice of other coverage, Medicare entitlement, or cessation of disability under COBRA. 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 any of the following events occurs:

- A qualified beneficiary, after electing COBRA, first becomes covered under another group health plan for a benefit (*check applicable benefits*): medical dental vision plan coverage covered under COBRA (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- A qualified beneficiary, after electing COBRA for medical benefits, first becomes entitled to Medicare (Part A, Part B, or both); or
- The Social Security Administration determines that a disabled qualified beneficiary is no longer disabled, if the maximum period of COBRA coverage previously was extended due to the qualified beneficiary's disability.

Deadline:

If you are providing notice of:	The deadline for this notice is:
Other Coverage (a qualified beneficiary, after electing COBRA, first becomes covered by other group health plan coverage) (<i>check applicable benefits</i>): <input type="checkbox"/> medical <input type="checkbox"/> dental <input type="checkbox"/> vision	30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary
Medicare Entitlement (a qualified beneficiary, after electing COBRA for medical benefits, first becomes entitled to Medicare Part A, Part B, or both)	30 days after the beginning of Medicare entitlement (as shown on Medicare card)
Cessation of Disability (a Social Security Administration determination that a qualified beneficiary is no longer disabled)	30 days after the date of the Social Security Administration's determination

Notice Procedures: You must follow the Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability found in the Summary Plan Description.

Warning: If one of the events listed in this notice occurs, COBRA coverage will be terminated (retroactively if applicable) as described in the Plan's Summary Plan Description, regardless of whether or when you provide this Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability.

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:

Initial qualifying event: _____

Date of initial qualifying event: _____

3. Event Description (*check one and complete*):

Qualified beneficiary has become covered by other group health (*check applicable benefits*): medical dental
 vision coverage after electing COBRA

Print name(s) of qualified beneficiary(ies) who obtained other coverage: _____

Address of qualified beneficiary(ies): same as employee's address different address (*provide address(es)*):

Date that other group health plan coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, provide date that these exclusions were exhausted or satisfied):

Is evidence of the effective date of the other coverage enclosed with this notice? Yes No

Qualified beneficiary has become entitled to Medicare after electing COBRA for medical benefits

Print name of qualified beneficiary who became entitled to Medicare: _____

Address of qualified beneficiary: same as employee's address different address (*provide address*):

Date that Medicare entitlement began: _____

Is a copy of the qualified beneficiary's Medicare card enclosed with this notice? Yes No

Qualified beneficiary ceased to be disabled

Print name of qualified beneficiary: _____

Address of qualified beneficiary: same as employee's address different address (*provide address*):

Date disability ended (according to Social Security Administration determination): _____

Date of Social Security Administration's determination: _____

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

4. 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 former dependent child

other (*explain*): _____

Signature: _____

Date: _____

Print Name: _____

Telephone Number: _____

Address: _____

Where to send the completed Notice of Other Coverage, Medicare Entitlement, or Cessation 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 received: _____

Date of postmark, if mailed: _____

COBRA election date: _____

Evidence of effective date of other coverage enclosed? Yes No N/A

Copy of Medicare card enclosed? Yes No N/A

Copy of Social Security determination enclosed? Yes No N/A

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