

NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSATION OF DISABILITY

Form and Notice Procedures

This form (including the Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability appearing at the end of this form) is part of the Plan's COBRA election notice. 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 other provisions of the Plan's COBRA initial notice and election notice. You may also obtain copies of these documents from your employer or MEBS.

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 other group health plan coverage (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, first becomes entitled to Medicare (Part A, Part B, or both); or
- The Social Security Administration determines that a disabled 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)	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, 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 as it appears below.

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.

Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

How to Provide Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

You must mail or hand-deliver this notice to the former employer, as stated at the front of your most recent summary plan description. Your notice must be provided no later than the deadline described on the first page of this form.

This form should be used to provide the employer a Notice of Other Coverage, a Notice of Medicare Entitlement, or a Notice of Cessation of Disability, and all of the applicable items on the form should be completed.

Additional Information Required for Certain Notices

If you are providing a Notice of Other Coverage, your notice should include evidence of the effective date of the other coverage (such as a copy of the insurance card or application of coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include a copy of the Medicare card showing the date of Medicare entitlement.

If you are provided Notice of Cessation of Disability, your notice must include a copy of the Social Security Administration's determination that the qualified beneficiary is no longer disabled.

Who May Provide Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

The covered employee (i.e. the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

Complete This Portion

Identify the Covered Employee (the employee or former employee who is or was covered under the Plan):

Name of Employee (please print): _____

Address of Employee: _____

Identify Initial Qualifying Event (the event that started your COBRA coverage)

- Termination of employment Reduction of hours

Date of initial qualifying event _____

Event Description (check one and complete):

- Qualified beneficiary has become covered by other group health plan coverage after electing COBRA

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

Address of each qualified beneficiary: Same as employee's address Different address (provide address)

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

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

Address of qualified beneficiary: Same as employee's address Different address (provide address)

Date that Medicare entitlement began or will begin: _____

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 who ceased to be disabled: _____

Address of beneficiary: Same as employee's address Different address (provide address)

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

Is a copy of the Social Security Administration's determination enclosed with this notice? Yes No

Certification, Signature, and Date:

I certify that the above information is true and correct. I am the (check one):

- former employee spouse or former spouse former dependent child

other (explain) _____

Signature _____

Address _____

Print Name _____

Telephone Number _____

Date: _____