

**NOTICE TO *EXTEND* COBRA CONTINUATION COVERAGE  
(Disability or Second Qualifying Event)**

A qualified beneficiary should use this form to report an event that may result in the extension of COBRA continuation coverage. **It is the qualified beneficiary's responsibility to notify PEBA Insurance Benefits within the original 18- or 29-month continuation period and by the deadline provided below.** In no event will continuation coverage last beyond 36 months from the date of the original qualifying event. **Return this completed form to your COBRA Administrator at the same address you use for your premium payment.**

If you are providing notice of:	The deadline for providing this notice is:
Disability	<b>60 days after</b> 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 loses (or would lose) coverage under PEBA Insurance Benefits as a result of the covered employee's termination or reduction of hours
A second qualifying event, including death of a covered employee, divorce or legal separation from the covered employee, or a child loses eligibility for coverage	<b>60 days after</b> the date of the second qualifying event

Employee who was covered under PEBA Insurance Benefits (please print): \_\_\_\_\_

BIN or SSN of employee who was covered under the Plan: \_\_\_\_\_

Name of qualified beneficiary making this report (please print): \_\_\_\_\_

**IDENTIFY THE REASON FOR *EXTENDING* COBRA (check applicable box(es) and complete information)**

**Qualified beneficiary has become disabled according to Social Security Administration's determination**

Name of qualified beneficiary who became disabled: \_\_\_\_\_

Date disability began (according to Social Security Administration's determination): \_\_\_\_\_

Date of the Social Security Administration determination: \_\_\_\_\_

**IMPORTANT:** Include a copy of the Social Security Administration's determination.

**Covered employee and spouse (qualified beneficiary): ( ) divorced ( ) separated**

Name and address of spouse: \_\_\_\_\_

Date of divorce or legal separation: \_\_\_\_\_

**IMPORTANT:** Include a copy of the signed divorce decree or the signed court order showing a divorce is in progress.

**Death of covered employee** Date of covered employee's death: \_\_\_\_\_

**IMPORTANT:** Include a copy of the death certificate.

**Employee's child (qualified beneficiary) lost eligibility**

Name of child who ceased to be eligible: \_\_\_\_\_

Date child ceased to be eligible: \_\_\_\_\_ due to:

( ) Attaining age 26

**I hereby certify that the above information is true and correct.**

\_\_\_\_\_  
Signature of qualified beneficiary making this report (if a minor, then parent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Benefits Administrator (for local subdivisions or COBRA subsidy individuals)

\_\_\_\_\_  
Group #