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 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	**Within 60 days after** the latest of: (i) the date of the determination of disability under the Social Security Act; (ii) the date the Qualifying Event occurs; (iii) the date the Qualified Beneficiary loses or would lose coverage; or (iv) the date the Qualified Beneficiary is notified of their notice obligation. The Qualified Beneficiary must notify the Plan Administrator within 30 days of any determination that the person is no longer disabled.
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.	**60 days after** 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**

Name and address of spouse: _____
Date of divorce: _____
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 #