SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
Insurance Benefits

NOTICE TO *TERMINATE* COBRA CONTINUATION COVERAGE

(Other Coverage, Medicare Entitlement, or Cessation of SSA Disability)

A qualified beneficiary should use this form to report an event that terminates COBRA continuation coverage. This includes gaining other coverage, becoming entitled to Medicare, or ceasing SSA disability. If one of these events occurs, COBRA continuation coverage will be terminated (retroactively, if applicable) regardless of whether or when he provides this notice. PEBA Insurance Benefits also will recoup any claims paid after the date he was no longer eligible for COBRA continuation coverage. **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:
Other coverage (a qualified beneficiary, after electing COBRA, first becomes covered by other group health plan)	**30 days after** the date other coverage becomes effective or, if later, 30 days after satisfaction of any preexisting condition exclusion or limitation with respect to any preexisting condition of the qualified beneficiary
Medicare entitlement (a qualified beneficiary, after electing COBRA, first becomes covered by Medicare Part A, Part B, or both)	**30 days after** the date Medicare coverage begins (as shown on the Medicare card)
Cessation of a disability (after coverage was extended to 29 months, Social Security Administration determines that a qualified beneficiary is no longer disabled)	**30 days after** the date of the Social Security Administration's determination

Name of employee who was covered under the Plan (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 *TERMINATING* COBRA (check applicable box(es) and complete information)

❑ **Qualified beneficiary became covered by other group health plan after electing COBRA**

Name of qualified beneficiary(ies) who gained other coverage: _____

Date other group health plan coverage became effective: _____

IMPORTANT: *Include letter on company letterhead showing effective date of other coverage and who is covered.*

❑ **Qualified beneficiary became covered by Medicare after electing COBRA**

Name of qualified beneficiary(ies) who became covered by Medicare: _____

Date Medicare coverage became effective: _____

IMPORTANT: *Include a copy of the Medicare card.*

❑ **Qualified beneficiary ceased to be disabled**

Name of qualified beneficiary(ies) who ceased to be disabled: _____

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

Date of the Social Security Administration's determination: _____

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

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

_____ _____
Signature of qualified beneficiary making this report (if QB is a minor, then parent) Date

_____ _____
Signature of Benefits Administrator (for local subdivisions or COBRA subsidy individuals) Group #