COBRA

Notice by Qualified Beneficiaries of SSA Disability Determination

IMPORTANT: COBRA coverage may be extended for up to 29 months (from the date of the first qualifying event) if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and must last until the end of the 18-month COBRA coverage period. You must timely deliver this notice to Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, AL 35298-0001, Fax: 205 220-6884 or 1 888 810-6884 (toll free) before the end of the 18-month period of COBRA coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage is lost under the Plan because of the initial qualifying event, or (iii) the date of the SSA disability determination. If you do not deliver this notice by the due date above, you will lose your right to an extension of COBRA continuation coverage. Please refer to the summary plan descriptions for your Plan for more information about COBRA coverage.

Group Health Plan Information: ______________________________

GROUP NAME GROUP NUMBER

Please check the group health plans (the "Plan") under which you had coverage on the day before the qualifying event:

☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP

DATE OF TERMINATION/REDUCTION IN HOURS
MM/DD/YYYY

Qualified Beneficiary Information:

Please complete the information below for each person (the employee, spouse and/or dependent children) who have COBRA coverage under the Plan:

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

RELATIONSHIP TO EMPLOYEE

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

RELATIONSHIP TO EMPLOYEE

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

RELATIONSHIP TO EMPLOYEE

Notice of SSA Disability Determination: Please complete all information below:

NAME OF DISABLED QUALIFIED BENEFICIARY

DATE OF QUALIFIED BENEFICIARY DISABILITY	DATE OF SSA DISABILITY DETERMINATION
MM/DD/YYYY	MM/DD/YYYY

You must include a copy of the SSA disability determination letter with this notice.

SIGNATURE PRINT NAME DATE