NOTICE OF DISABILITY
Employee Benefits Plan (the Plan)

When to Use This Notice:
Use this Notice if the qualified beneficiary meets both of the following conditions:

- The qualified beneficiary became entitled to COBRA coverage due to a qualifying event that was either the termination of the covered employee's employment or the reduction of the employee's hours of work; AND
- The Social Security Administration has determined that the qualified beneficiary was disabled on any day of the first 60 days following the termination of employment or reduction in hours.

(Note: If the Social Security Administration made the disability determination before the covered employee's termination of employment or reduction of hours, you may still use this Notice of Disability form to report the earlier disability determination, so long as the qualified beneficiary remains disabled.)

Deadlines:
There are two deadlines for providing this Notice of Disability. You must satisfy both deadlines. *First*, you must provide this Notice within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours.

Second, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

How to Provide Notice of Disability:
Notification must be received by the COBRA Administrator. The COBRA Administrator is:
Trinity Marketing Services
PO Box 193
Marlton, NJ 08053
Your Notice must be in writing (using this form) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic notices (including emailed or faxed notices) are not acceptable. If you mail your Notice, it must be postmarked on or before the two deadlines described above. If you hand-deliver your Notice, it must be received by the individual at the address specified above on or before the two deadlines described above.

> **Warning: If your Notice is late, or if it is not completed and provided to the COBRA Administrator as described above, no extended COBRA coverage will be available to any qualified beneficiary.**

For more information about this Notice, 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 (for 18-month qualifying events). (You may obtain copies of these documents from the COBRA Administrator.)

Complete This Portion:
Identify the Covered Employee (the employee or former employee who is or was covered under the Plan) **and Date of Qualifying Event:**

Print name of covered employee:	Employee's Plan ID#:	Employee's date of birth:
Address of covered employee:		
Date of qualifying event (date employee's employment terminated or date employee's hours were reduced):		

Identify All Qualified Beneficiaries:
Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

Name of qualified beneficiary:	Address of qualified beneficiary:
	Address is same as employee's address above
	Address is same as employee's address above
	Address is same as employee's address above
	Address is same as employee's address above
	Address is same as employee's address above

Identify Disabled Qualified Beneficiary:

Name of disabled qualified beneficiary:	Address of disabled qualified beneficiary: Address is same as employee's address above Other [enter here]

Social Security Administration's Determination of Disability:

Date of SSA determination:	Date that disabled qualified beneficiary became disabled (according to SSA determination):

You must provide a copy of the Social Security Administration's determination with this notice. Is a copy enclosed?	Yes No
Has the Social Security Administration subsequently determined that the qualified beneficiary is no longer disabled?	Yes No

Contact Information:

Print name of person signing this Notice:	I am the (check one): former employee spouse or former spouse disabled qualified beneficiary other (explain)
Address: Same as employee’s address above Same as spouse’s address above Same as child’s address above Other (enter here)	Telephone number: Email address:

Certification, Signature, and Date:

I certify that the above information is true and correct.

NAME:____________________ WET SIGNATURE ____________________

SIGNATURE DATE: ____________________

For Plan Use Only:

Date Notice received:	Date of postmark, if mailed:
Attach original envelope with postmark	Yes No (explain)

Social Security Administration determination of disability enclosed?	Yes No