Self Insurance Pool of Greater Kansas City, Inc.
Blue Springs R-IV School District

Notice of Other Coverage or Medicare Entitlement

When to Use This Notice:

Use this Notice if the following conditions are satisfied:

1. You or another qualified beneficiary is receiving COBRA health plan continuation coverage; AND

2. After COBRA coverage was elected, either of the following events occurs:

   - You or another qualified beneficiary becomes covered under other group health plan coverage ("other coverage"); or

   - You or another qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) ("Medicare entitlement").

Deadline:

If you are providing notice of:	**The deadline for this notice is:**
Other Coverage	30 days after the other coverage becomes effective or, if later, 30 days after any exclusion under the other plan for a preexisting condition of the qualified beneficiary is exhausted or satisfied
Medicare Entitlement	30 days after Medicare entitlement (as shown on Medicare card)

How to Provide Notice:

Mail, hand-deliver, or email this Notice to:

COBRA Administrator
Fullerton CPA's
2001 NW Jefferson Street
Blue Springs, MO 64015
(816) 224-4195 x 209
dayla@fullertoncpa.com

If a qualified beneficiary becomes covered by another group health plan or entitled to Medicare, COBRA coverage will be terminated (retroactively, if applicable) as described in the Plan's Summary Plan Description, regardless of whether or when you provide this Notice of Other Coverage or Medicare Entitlement.

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 Plan's COBRA election notice. (You may obtain copies of these documents from ***https://www.bssd.net/domain/45*****.**)

Complete This Portion:

Identify the Covered Employee (the employee or former employee who is or was covered under the Plan):

Print name of covered employee:	Employee's Plan ID or SSN #:	Employee's date of birth:
Address of covered employee:		

Event Description (Check box 1 or 2 and complete):

☐ **1. Qualified Beneficiary has become covered by other group health plan coverage.**	
Name of qualified beneficiary(ies) who obtained other coverage:	Address of qualified beneficiary(ies): ☐ same as spouse's address ☐ other (provide address(es))
Date that other group health plan coverage became effective:	
Did any exclusion apply to the preexisting condition of a qualified beneficiary?	☐ Yes ☐ No
If you answered "yes" to the question above, provide date the exclusion has been or will be exhausted or satisfied:	

☐ **2. Qualified beneficiary has become entitled to Medicare.**	
Name of qualified beneficiary who became entitled to Medicare:	Address of qualified beneficiary(ies): ☐ same as spouse's address ☐ other (provide address(es))
Date Medicare entitlement began:	
Please provide a copy of the qualified beneficiary's Medicare card.	
Is a copy enclosed?	☐ Yes ☐ No

Contact Information:

Print name of person signing this Notice:	I am the (check one): ☐ former employee ☐ spouse or former spouse ☐ former dependent child ☐ 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.

_____ _____

Signature Date

For Plan Use Only

Date Notice received: _____	Date of postmark, if mailed: _____
Attach original envelope with postmark	☐ Yes ☐ No (explain)
Evidence of effective date of other coverage enclosed?	☐ Yes ☐ No ☐ N/A
Copy of Medicare card enclosed?	☐ Yes ☐ No ☐ N/A