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

Notice of Disability

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 (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) 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,* you must provide this Notice within 18 months after the covered employee's termination of employment or reduction of hours.

How to Provide Notice of Disability:

Mail or hand-deliver this Notice to:

COBRA Administrator
Fullerton CPAs
2001 NW Jefferson Street
Blue Springs, Missouri 64015
(816) 224-4195 x209
dayla@fullertoncpa.com

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. 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 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 or at ***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) **and the Date of Qualifying Event**:

Print name of covered employee:	Employee's Plan ID or SSN#:	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 the 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 ☐ 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)
Social Security Administration determination of disability enclosed?	☐ Yes ☐ No