COBRA - Notice of Disability Form

Instructions and Notice Procedures

Within this form, "you" and "your" refer to the employee covered under their employer's group health plan (the "Plan"), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either. A notice provided by any of these individuals will satisfy responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice. Within this form, "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator. **This form is part of** the Plan's COBRA initial notice and COBRA election notice. **For more information** about this form, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's Summary Plan Description (SPD) and the other provisions of the Plan's COBRA initial notice and election notice (for qualifying events). You may obtain copies of these documents from your employer. **Use this form when the Social Security Administration (SSA) determined a qualified beneficiary became disabled** within the first 60 calendar days following the qualifying event of a termination of employment or a reduction of hours of the employee covered under the Plan. If the SSA made the disability determination *before* the employee's termination of employment or reduction of hours, you may still use this form to report the determination to us as long the qualified beneficiary remains disabled and you provide this notice by the **Submission Deadline** below.

Submission Deadline: You must provide this Notice of Disability (your "Notice") within 60 calendar days of the latest of:

- The date of the SSA's determination regarding your disability status;
- The date of the employee's termination of employment or reduction of hours; and
- The date you'd lose coverage under the terms of the Plan as a result of termination of employment or reduction of hours.

Submission Requirements

- Complete all applicable fields in this form to the best of your knowledge and include all pages of the form with your Notice.
- **Include/attach *a copy of* the "Notice of Award" letter you received from the SSA**. Keep the original letter for your own records and send us *a copy of* the letter. You may find an example of this letter on our website.

If your Notice doesn't contain all required material, we will consider it timely only if *all* of the following conditions are met:

- You provide this Notice to us through one of the **Submission Options** by the **Submission Deadline**;
- From your Notice, we're able to: 1) Determine it relates to the Plan and a qualified beneficiary's disability, 2) Identify the covered employee, the qualified beneficiary/beneficiaries; and the date the qualifying event occurred;
- Your Notice meets the Plan's requirements; and
- If applicable, you supplement your Notice in writing with any additional information/material needed to meet Plan requirements within 15 business days of request for more information (or, if later, by the **Submission Deadline**).

If your Notice meets all **Submission Requirements**, we'll treat your Notice as having been provided on the date we receive all required information/material, but will still consider your Notice as timely. Otherwise, we'll consider your Notice to be incomplete and we won't extend your COBRA coverage.

Submission Options

✓ **Option 1: Email**:

1. Go to mi.accesshma.com
2. Click the **Download pdf** option under **COBRA Notice of Disability Form** and fill out the form in compatible software like Adobe Reader/Acrobat
3. Email your completed form and all supporting material to: COBRArequest@accesstpa.com

✓ **Option 2: Mail** the completed form and all supporting material, postmarked by the **Submission Deadline**, to:
HMA
Attn: COBRA
PO Box 53168
Bellevue, WA 98015-3168

Any questions? We're here to help! Contact Customer Care at (833) 865-0141.

HMA

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Employee Information

Provide information on the employee covered by the Plan. This person is also known as the Subscriber.

Full Name _____ **Employee ID Number**[?] _____

Mailing Address _____

Group Name or Plan Name _____ **Group ID Number**[?] _____

[?] *This information can be located on your insurance ID card. "Employee ID" is also called "Member ID".*

Employee's Qualifying Event Information

Select the **one** initial qualifying event that started the employee's COBRA coverage and enter the date.

○ Termination *OR* ○ Reduction in Hours **Date of Qualifying Event** _____

Disabled Qualified Beneficiary Information

List the person who meets the disability requirements on page 1. **You must also include a copy of your SSA Notice of Award letter.**

Full Name _____

Mailing Address _____ ☐ *Same as employee*

SSA Notice of Award Letter Date _____ **SSA Disability Determination Date** _____

Qualified Beneficiary Information

List all beneficiaries who lost group health coverage (but are still receiving COBRA coverage) due to the employee's event above. If you need to list more people than this space allows, include an attachment listing all of the information below for each additional person.

Full Name (first, middle, last)	**Mailing Address** (if different from the employee's)
	☐ *Same as employee*
	☐ *Same as employee*
	☐ *Same as employee*

Attachments

You must include a copy of your SSA Notice of Award letter. You may find an example of this letter on our website.

Signature

_____ _____ _____

Printed Name (First and Last) **Phone Number** **Email Address**

_____ _____ _____

Signature **Date** **Relationship to Employee**

By signing this Form you attest that 1) You are the employee referenced herein, a qualified beneficiary of the employee (such as a spouse, a former spouse, or a dependent), or are otherwise legally authorized to represent them; 2) The information listed herein is correct to the best of your knowledge; 3) You understand and acknowledge all stipulations listed herein.