DMBA

NOTICE OF DISABILITY

Deseret Healthcare Employee Benefits Plan and Deseret Healthcare Flexible Benefits Plan

INSTRUCTIONS

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.

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 Deseret Healthcare Employee Benefits Plan and the Deseret Healthcare Flexible Benefits Plan (collectively referred to herein as the "Plan") as a result of the termination of employment or reduction of hours. Your notice of disability must also be provided within 18 months after the covered employee's 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.

If your notice is late, or if it is not completed and provided to DMBA as described above, no extended COBRA coverage will be available to any qualified beneficiary.

Return notice of disability to DMBA by:

Note: Submit this form only once. If you sign it electronically online, do not send a duplicate by mail, email, or fax.

Mail: DMBA
P.O. Box 45530
Salt Lake City, UT 84145

Fax: 801-578-5933

Email: enrollmenthelp@dmba.com

Your notice must be in writing (using this form) and must be mailed, faxed, emailed, or signed electronically. Oral notice, including notice by telephone, is not acceptable. If you mail your notice, it must be postmarked on or before the two deadlines described above. If you fax or email your notice, it must be received at the address specified above on or before the two deadlines described above.

For more information about this notice, the Plan's notice procedures, and your COBRA rights and obligations, consult the summary plan descriptions for the Plan 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 DMBA.

PARTICIPANT INFORMATION AND QUALIFYING EVENT

Employee name: _____ DMBA ID Number: _____

Address: _____

Birth date: _____ Phone: _____ Email: _____

Date of qualifying event: _____

ALL QUALIFIED BENEFICIARIES

Print names of all the qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

Name	Address

SOCIAL SECURITY ADMINSTRATION'S DETERMINATION OF DISABILITY

Name of disabled qualified beneficiary: _____

Address: _____

Date of Social Security Administration's determination: _____

Date disabled qualified beneficiary became disabled (according to the Social Security Administration's determination): _____

Has the Social Security Administration subsequently determined that the qualified beneficiary is no longer disabled? ☐ Yes ☐ No

You must provide a copy of the Social Security Administration's determination with this notice.

SIGNATURE

Signature: _____ Date: _____

Person signing (check one): ☐ Employee ☐ Spouse or former spouse ☐ Qualified beneficiary