DMBA

NOTICE OF CESSATION OF DISABILITY

Deseret Healthcare Employee Benefits Plan and Deseret Healthcare Flexible Benefits Plan

INSTRUCTIONS

Use this notice only if these three events have happened:

- You became entitled to COBRA coverage because the covered employee's employment terminated or hours of work were reduced; and
- The maximum period of COBRA coverage previously was extended because you or another qualified beneficiary were disabled; and
- The Social Security Administration determined the disabled qualified beneficiary is no longer disabled.

Provide this notice within 30 days after the date of the Social Security Administration's determination.

Note: when a disabled qualified beneficiary is determined to be no longer disabled, COBRA coverage will terminate (retroactively if applicable) as described in the summary plan description for the Deseret Healthcare Employee Benefits Plan and the Deseret Healthcare Flexible Benefits Plan (collectively, the "Plan") even if you fail to provide this notice of cessation of disability.

Return notice of cessation 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

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 provisions of the Plan's COBRA election notice. You may obtain copies of these documents from DMBA.

PARTICIPANT INFORMATION AND QUALIFYING EVENT

Employee name: _____ DMBA ID Number: _____

Address: _____

Birth date: _____ Phone: _____ Email: _____

Initial qualifying event was (check one): ☐ Termination of employment ☐ Reduction in hours of employment

DISABILITY DETERMINATION DESCRIPTION

Name of disabled qualified beneficiary: _____

Address: _____

Date of Social Security Administration's determination: _____

Date disability ended (according to Social Security Administration's determination): _____

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

Signature: _____ Date: _____

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