DMBA

NOTICE OF OTHER COVERAGE OR MEDICARE ENTITLEMENT

Deseret Healthcare Employee Benefits Plan and Deseret Healthcare Flexible Benefits Plan

INSTRUCTIONS

Use this notice if the following conditions are satisfied:

- You or another qualified beneficiary is receiving COBRA health plan continuation coverage; and
- 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").

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)

Note: 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 summary plan description for the Deseret Healthcare Employee Benefits Plan and the Deseret Healthcare Flexible Benefits Plan (collectively, the "Plan"), regardless of whether or when you provide this notice of other coverage or Medicare entitlement.

Return notice of other coverage or Medicare entitlement 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 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: _____

Event description (check one):

☐ A qualified beneficiary has become covered by other group health plan coverage

☐ A qualified beneficiary has become entitled to Medicare

OTHER COVERAGE

Name of qualified beneficiary: _____

Address: _____

Date that other group health plan coverage became effective: _____

Did any exclusion apply to the preexisting condition of a qualified beneficiary? ☐ Yes ☐ No

If "yes," provide the date the exclusion has been or will be exhausted or satisfied: _____

MEDICARE ENTITLEMENT

Name of qualified beneficiary: _____

Address: _____

Date Medicare entitlement began: _____

Please provide a copy of the qualified beneficiaries Medicare card with this notice.

SIGNATURE

Signature: _____ Date: _____

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