NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSATION OF DISABILITY FORM

____

Employer Name/Plan Sponsor

When to Use This Form:

Use this form when any of the following events occurs:

- A qualified beneficiary, after electing COBRA, first becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- A qualified beneficiary, after electing COBRA, first becomes entitled to Medicare(Part A, Part B, or both); or
- The Social Security Administration determines that a disabled qualified beneficiary is no longer disabled, if the maximum period of COBRA coverage previously was extended due to the qualified beneficiary's disability.

Deadline:

If you are providing notice of:	**The deadline for this notice is:**
Other coverage(a qualified beneficiary, after electing COBRA, first becomes covered by other group health plan coverage)	30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.
Medicare entitlement (a qualified beneficiary, after electing COBRA, first becomes entitled to Medicare Part A, Part B or both)	30 days after the beginning of Medicare entitlement (as shown on Medicare card)
Cessation of disability (a Social Security Administration determination that a qualified beneficiary is no longer disabled)	30 days after the date of the Social Security Administration's determination.

How to Provide Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability:

You must provide these notices to:

Tri-Star Systems
Attn: COBRA
16401 Swingley Ridge Road, Suite 250
Chesterfield, MO 63017

If one of the events listed in this notice occurs, COBRA coverage will be terminated (retroactively if applicable) as described in the Plan's summary plan description, regardless of whether or when you provide this Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability.

For more information about this form, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's summary plan description and the provisions of the Plan's COBRA election notice. (You may obtain copies of these documents from your former employer.)

NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSATION OF DISABILITY FORM

____

Employer Name/Plan Sponsor

Complete This Portion:

Identify the Covered Employee (the employee or former employee who is or was covered under the Plan):
Print name of employee:____
Address of Employee: ____
____

Identify Initial Qualifying Event:
Initial qualifying event: ____
Date of initial qualifying event: ______/______/___________

Event Description (Check one and complete):

- Qualified beneficiary has become covered by other group health plan coverage after election COBRA
  Print name of qualified beneficiary(ies) who obtained other coverage: ___________________________________
  ____
  Date that other group health plan coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, provide date that these exclusions were exhausted or satisfied):
  ______/______/___________
  Please include evidence of the effective date of the other coverage. Is such evidence enclosed?
  • Yes • No
- Qualified beneficiary has become entitled to Medicare after electing COBRA
  Print name of qualified beneficiary who became entitled to Medicare: ___________________________________
  Date that Medicare entitlement began: ______/______/___________
  Please provide a copy of the qualified beneficiary's Medicare card. Is a copy enclosed? • Yes • No
- Qualified beneficiary ceased to be disabled
  Print name of qualified beneficiary: ____

  Date disability ended (according to Social Security Administration determination): ______/______/__________
  Date of Social Security Administration's determination: ______/______/__________
  Please provide a copy of the Social Security Administration's determination. Is a copy enclosed with this notice?
  Yes No

  Address of qualified beneficiary(ies): • same as employee's address • different address (provide address)
  ____
  ____

Certification, Signature and Date:
I certify that the above information is true and correct.
I am the (check one): employee or former employee spouse or former spouse former dependent child
other (explain) ____

____ ________________________
Signature Date

____
Print Name
____
Address
____
Address
(_________) __________ -- ____________________________
Telephone Number