CN

COBRA Notification of Other Coverage, Medicare Entitlement, or Cessation of Disability

University of Michigan Group Health Plan (the Plan)

BTT Use Only
Event Date _____

Input Elections _____

INSTRUCTIONS

This form (including the second page, "Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability") is part of the Plan's COBRA Election Notice. To obtain more information about this form, the Plan's notice procedures, and your COBRA rights and obligations, refer to your COBRA Initial Notice, Election Notice, or contact the HR/Payroll Service Center.

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

Notice Procedures:

You must follow the Procedures for Notification of Other Coverage, Medicare Entitlement, Or Cessation of Disability described on the reverse side of this form. Please print all information in **black** ink.

Please Note: If one of the events listed in this notice occurs, COBRA coverage will be terminated (retroactively if applicable), regardless of whether or when you provide this Notification of Other Coverage, Medicare Entitlement, or Cessation of Disability.

1. Identify the Covered Faculty or Staff Member

Name (Last, First, Middle Initial)	UMID (if known)	U.S. Social Security Number
Street Address	City, State, Zip	Home Phone Number

2. Indicate the Event

☐ **Qualified Beneficiary Has Become Covered By Other Group Health Plan after Electing COBRA**

Name of Qualified Beneficiary who Obtained Other Coverage	U.S. Social Security Number	UMID (if applicable)

Is evidence of the effective date of the other coverage enclosed with this notice? ☐ Yes ☐ No	Date that other group health plan coverage became effective:	If there were any preexisting condition exclusions applicable to the qualified beneficiary, provide date that these exclusions were exhausted or satisfied:

☐ **Qualified Beneficiary Has Become Entitled To Medicare after Electing COBRA**

Name of Qualified Beneficiary who Became Entitled to Medicare	U.S. Social Security Number	UMID (if applicable)

Is a copy of the qualified beneficiary's Medicare card enclosed with this notice? ☐ Yes ☐ No	Date that Medicare entitlement began:

☐ **Qualified Beneficiary Ceased to be Disabled**

Name of Qualified Beneficiary	U.S. Social Security Number	UMID (if applicable)

Is a copy of the Social Security Administration's determination enclosed with this notice? ☐ Yes ☐ No	Date disability ended (according to Social Security Administration determination):	Date of Social Security Administration's determination:

3. Address of Qualified Beneficiary Named Above

☐ **Same as Covered Faculty or Staff Member** ☐ **Different Address (Provide Below)**

Qualified Beneficiary's Street Address	City, State, Zip	Home Phone Number

4. Certification and Signature

I have read and agree to the terms and conditions listed on the back of this form. I certify the information provided above is correct to the best of my knowledge.

_____ _____

Signature Date Signed

Procedures for Notification of Other Coverage, Medicare Entitlement, or Cessation of Disability

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

These procedures apply to the following notices that you are required to provide to the University of Michigan:

- **Notice of Other Coverage**—a notice that a qualified beneficiary has become covered, after electing COBRA, 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);
- **Notice of Medicare Entitlement**—a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both; and
- **Notice of Cessation of Disability**—a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled.

You may return this notice to SSC Benefits Transactions by faxing it to the number listed at the bottom of this page, or the other means listed at the bottom of this page.

Information and Form Required for All Notices

This form may be used to provide the University of Michigan a Notice of Other Coverage, a Notice of Medicare Entitlement, or a Notice of Cessation of Disability, and all of the applicable items on the form should be completed.

This information may be provided to the University of Michigan in writing without using this form; however, all of the applicable items on the form must be provided.

Additional Information Required for Certain Notices

- If you are providing a Notice of Other Coverage, your notice should include evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).
- If you are providing a Notice of Medicare Entitlement, your notice should include a copy of the Medicare card showing the date of Medicare entitlement.
- If you are providing a Notice of Cessation of Disability, your notice must include a copy of the Social Security Administration's determination that the qualified beneficiary is no longer disabled.

Who May Provide Notices

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

COBRA Coverage Will Terminate Regardless of Whether or When Notice is Provided

- If a qualified beneficiary first becomes covered by other group health plan coverage after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable), regardless of whether or when a Notice of Other Coverage is provided.
- If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable), regardless of whether or when a Notice of Medicare Entitlement is provided.
- If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable), regardless of whether or when a Notice of Cessation of Disability is provided.

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?
If you have any questions, view the Benefits Office website at benefits.umich.edu, or call the SSC HR Contact Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.) Monday through Friday from 8 a.m. to 5 p.m.

How to Return Your Signed and Completed Form

By Fax

Fax it to 734-763-0363
Keep a copy of the fax transmission report with your form in your records.

By Mail
Make a copy for your records and send the original by **Campus Mail or U.S. Mail** to:
SSC Benefits Transactions
G300 Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1278

Drop It Off In Person
Bring a photocopy of your completed form and ask the receptionist to stamp the copy "received" for your records.

U-M Flint
UHR - Flint
213 University Pavilion
303 East Kearsley
Flint, MI 48502-1950