

Carpenters Health and Security Plan of Western Washington

COBRA Application For 11-Month Disability Extension

Eastern Washington, Idaho, Montana, Wyoming

- Please complete this application in its entirety and return it to Carpenters Trusts. You must include a copy of the *Social Security Disability Determination Notice*.
- Enclose a check or money order made payable to “Carpenters Trusts of Western Washington.” Please review the rates for a disability extension on the reverse side of this application.
- Your completed application must be received within 30 days of the termination of the first 18 months of COBRA Coverage.
- Carpenters Trusts will notify you, in writing, of the acceptance or denial of your application.

Participant's Name: _____

Social Security Number: _____

Qualified Beneficiary Information

Date of Notice:

Name: Last, First, Middle		Social Security Number		
_____		_____		
Disabled Person's Name: Last, First, Middle		Social Security Number		
_____		_____		
Mailing Address	Street	City	State	Zip
_____	_____	_____	_____	_____
Telephone Number	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
() _____	_____	_____		
Eligible Dependents (List Dependent's Legal Name):		Date of Birth	Relationship	
_____		_____	_____	
_____		_____	_____	
_____		_____	_____	

11-Month Social Security Disability Extension

As described in the *COBRA Coverage Election Notice* accompanying your original COBRA Application, in the event of a reduction in hours of employment or termination of employment, COBRA Coverage can be extended if a qualified beneficiary is determined disabled by the Social Security Administration either before the 18-month qualifying event or within the first 60 days of COBRA Coverage. In this situation, the disabled individual and all qualified beneficiaries are eligible to extend COBRA Coverage an additional 11 months beyond the original 18, to a maximum of 29 months. The purpose of this extension is to allow the disabled person to continue COBRA Coverage until he or she becomes entitled to Medicare. Only those dependents who were initially covered under COBRA and are currently covered under COBRA are eligible.

The Social Security Administration must make the final determination within the first 18 months of the COBRA continuation period and the qualified beneficiary **must notify Carpenters Trusts both within the 18-month period and within the 60 days of determination.** To qualify for the extension, you must submit to Carpenters Trusts a copy of the *Social Security Disability Determination Notice* within 60 days of the date of the notice and before the end of the 18-month COBRA Coverage period. Thereafter, if there is a final determination of non-disability, the qualified beneficiary must notify Carpenters Trusts within 30 days of that determination.

Choice of Benefits and Monthly Amount

Monthly contribution rates for coverage that includes the disabled individual during the additional 11 months are substantially higher than what you are currently paying. Payments must be made monthly to continue coverage. Bills are mailed in the first week of the month for the following month's coverage. Payment is due, in full, upon receipt of the bill but not later than 30 days from the beginning of the month to be covered. **If you fail to make the initial payment, or any subsequent monthly payment, in a timely fashion, your coverage will terminate.**

If you elect this 11-month extension, you are entitled to the coverage currently provided to you under COBRA. However, if you currently have both medical and dental benefits, you have the right to elect medical coverage only. However, dental benefits cannot be reinstated later. Please check the box below that applies to your situation. The rates for 2017 are:

Medical Benefits: \$1,511/month

Medical and Dental Benefits: \$1,681/month

Important: The accompanying *COBRA Coverage Election Notice* explains in detail your rights and responsibilities under the Trust's COBRA Coverage provisions. It provides additional information about the effect of your legal rights of not electing COBRA Coverage, what alternative coverage (if any) is available from the Trust and your notification obligations. This includes how to obtain an 11-month extension of COBRA Coverage if you or an eligible family member are determined disabled by the Social Security Administration. This includes notifying Carpenters Trusts within 60 days of receiving your Disability Determination. It also includes information about your responsibility to notify Carpenters Trusts within 60 days if a second qualifying event occurs while you are on COBRA. All notices to Carpenters Trusts must be in writing, identifying you, the eligible participant, and must be sent to Carpenters Trusts at the following address:

Carpenters Trusts of Western Washington
2200 Sixth Avenue, Suite 300
Seattle, WA 98121-1839

COBRA Coverage Election Agreement

I have read this application and the *COBRA Coverage Election Notice* and understand my rights to elect COBRA Coverage. I understand that if I elect COBRA Coverage and I fail to make any payment on time, this coverage will terminate. I also agree to notify Carpenters Trusts if I or any member of my family become covered under another group health plan or entitled to Medicare after the date of COBRA election. I also understand that the extended continuation will end the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled. **Important:** COBRA is provided subject to your eligibility. The plan reserves the right to terminate your COBRA Coverage retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Signature: _____ Date: _____