Notice of Disability Form
Montana Contractors' Association Health Care Trust (MCAHCT) Benefit Plan

INSTRUCTIONS:

Refer to the Plan's *COBRA Notice Procedures* for instructions on the content and delivery of this Notice. If you do not have a copy of the *Procedures*, ask the COBRA Administrator for a copy. **Deadline: Mail** this Notice within 60 days after the later of (a) the date of the Initial Qualifying Event identified in Section 2 below, (b) the date Plan coverage ends (or would end) due to the Initial Qualifying Event, or (c) the date of the SSA Determination identified in Section 5 below.

Address: Mail this Notice to the COBRA Administrator:

Allegiance Benefit Plan Management, Inc.

P. O. Box 3018

Missoula, MT 59806-3018

1. Identify the Employee

Print Name of Employee:	Address of Employee:

2. Identify Initial Qualifying Event

Initial Qualifying Event was: ☐ Termination of employment ☐ Reduction in hours	Date of Initial Qualifying Event

3. Identify Disabled Qualified Beneficiary

Name of Disabled Qualified Beneficiary	Address: ☐ Same as employee's address ☐ Different address (provide address)

4. Identify All Other Qualified Beneficiaries (Attach Sheet with Additional Names if Necessary)

Print Name of Qualified Beneficiary	Address: ☐ Same as employee's address ☐ Different address (provide address)
Print Name of Qualified Beneficiary	Address: ☐ Same as employee's address ☐ Different address (provide address)
Print Name of Qualified Beneficiary	Address: ☐ Same as employee's address ☐ Different address (provide address)

5. Social Security Administration Disability Determination

Date of SSA Disability Determination:

Date Qualified Beneficiary Became Disabled (according to SSA determination):

Has SSA subsequently determined that the qualified beneficiary is no longer disabled? ☐ Yes ☐ No

Have you enclosed a copy of SSA's Disability Determination? ☐ Yes ☐ No

6. Certification, Signature, Date and Telephone Number

I certify that the above information is true and correct.

I am the: ☐ Employee or Former Employee ☐ Disabled Qualified Beneficiary ☐ Other Qualified Beneficiary ☐ Other (explain):

Signature	Print Name
Date	Telephone Number

Attention! If the Disability Ends, You Must Provide Notice to COBRA Administrator!

If the Social Security Administration determines that the Qualified Beneficiary identified in Section 3 above is no longer disabled, the employee or an affected Qualified Beneficiary must provide a written Notice of Cessation of Disability to the COBRA Administrator at its address above within 30 days of the determination. For more information see the Plan's *COBRA Notice Procedures*.

For Office Use Only

Is the Social Security Administration determination of disability enclosed? ☐ Yes ☐ No

Date of Postmark: _____, 201_____

Was Notice timely? ☐ Yes ☐ No If "No," retain envelope. Has envelope been retained? ☐ Yes ☐ No