# SOCIAL SECURITY DISABILITY EXTENSION (SSDE)
COBRA

*If one of the qualified beneficiaries in your family is disabled and meets certain requirements, all of the qualified beneficiaries in your family are entitled to an 11-month extension of the maximum period of continuation coverage (for a total maximum period of 29 months of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension. The requirements are that the Social Security Administration (SSA) determines that the qualified beneficiary is disabled before the 60th day of continuation coverage and that the disability continues during the rest of the 18-month period of continuation coverage.*

## PRIMARY QUALIFIED BENEFICIARY INFORMATION

Name (First, MI, Last)

Social Security Number

Phone Number

Email Address

Employer Sponsoring Benefits

## SOCIAL SECURITY DISABILITY EXTENSION (SSDE) INFORMATION

**PLEASE SELECT ONLY ONE OF THE FOLLOWING:**

☐ **Applying for Social Security Disability Extension**

+ I have included a copy of the Notice of Award letter from the Social Security Administration (SSA). If this letter does not include the specific date I or another qualified beneficiary became disabled, I am aware I will need to request this additional information from the SSA. I understand that in order to be eligible, I must submit this completed form with a copy of the letter(s) from the SSA within 60 days of the date of the Notice of Award letter and before the original 18 months of COBRA benefits have expired. I also understand the disability must have occurred prior to or within the first 60 days of my COBRA start date. I understand my COBRA premiums may increase up to 150% of the original cost, if the SSDE is granted. I also understand that my continuation of coverage due to the SSDE will last no longer than 11 months beyond my original 18 months of COBRA coverage, and that should I request to cease the extension, my request must be made in writing.

☐ **Canceling a Social Security Disability Extension**

+ I have included a copy of the letter from the Social Security Administration (SSA) indicating that I or another qualified beneficiary is no longer disabled. I understand that I must submit this completed form with a copy of the letter from the SSA within 30 days of the date of that letter.

## QUALIFIED BENEFICIARY CERTIFICATION

I understand I am submitting this form to either continue or cancel my coverage due to the Social Security Disability Extension. In addition, I understand my request to extend coverage due to the Social Security Disability Extension does not guarantee coverage will be extended and that I will be notified in writing should my request be denied.

Qualified Beneficiary Signature

Date

**Return completed form to Surency at email: cobra@surency.com - fax: 316-272-4842**



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