NOTICE TO EMPLOYER OF SSA DISABILITY

(For qualified Beneficiaries already on COBRA continuation coverage)
Must Provide Within 60 Days of the SSA Determination and before the end of the 18 month COBRA continuation period
Please attach evidence from the SSA of the determination

Deliver or mail notice to:
Rollins College Human Resources Department
Attn: Dawn Peterson
1000 Holt Avenue-2718
Winter Park, FL 32789
FAX: 407-646-2188

Name of COBRA Qualified Beneficiary (QB): _____

Effective (date) _____ the following determination has been made by the Social Security Administration (SSA) which may entitle COBRA qualified beneficiaries and/or dependents to additional continued coverage under the COBRA group health plan. Check one:

- ☐ Covered COBRA QB has been determined to be disabled by the SSA
- ☐ Covered Dependent child has been determined to be disabled by the SSA
- ☐ Covered COBRA QB has been determined to be no longer disabled by the SSA
- ☐ Covered Dependent has been determined to be no longer disabled by the SSA

Following are the dependent(s) affected by the determination:

	Name of Dependent	Relationship to COBRA QB
1.	_____	_____
2.	_____	_____
3.	_____	_____

Send the necessary forms and information to:

_____
Name of Employee or Qualified Beneficiary

_____
Address or P.O. Box

_____
City, State, Zip Code

_____
Signature of COBRA QB & Printed Name Date