

Criteria:

In order to qualify for Disability Extension, you must meet the following criteria:

1. The qualifying event must be the covered employee's termination of employment or reduction of hours;
2. A qualified beneficiary (who may be the covered employee or the employee's spouse or dependent child) must be determined under the Social Security Act to have been disabled at any time during the first 60 days of COBRA coverage;
3. The qualified beneficiary must notify WageWorks of the Social Security disability determination within 60 days after the latest of:
 - a. The date of the Social Security disability determination
 - b. The date of the qualifying event (i.e., the employee's termination of employment or reduction in hours);
 - c. The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; and
 - d. The date on which the qualified beneficiary is informed (through the COBRA General Notice) of both the responsibility to provide the notice of disability and the plan's procedures for providing such notice to WageWorks; and
4. The qualified beneficiary must notify WageWorks of the Social Security disability determination before the end of the 18-month period following the qualifying event (i.e., the employee's termination of employment or reduction in hours).

Deadline:

The deadline for providing this Notice of Disability is 60 days after the latest of:

1. The date of the Social Security Administration's disability determination;
2. The date of the covered employee's termination of employment or reduction of hours; and
3. The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours.

Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction of hours.

How to Provide Notice of Disability:

You must mail this notice to:

WageWorks, Inc.
PO Box 14055
Lexington, KY 40512-4055

Your notice must be in writing (using this form) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

For more information about this form, the Plan's notice procedures, and your COBRA rights and obligations, consult the Plan's Summary Plan Description and the other provisions of the Plan's COBRA General Notice and election notice (for 18-month qualifying events). (You may obtain copies of these documents from your former employer.)

Warning: If your notice is late, or if it is not completed and provided to WageWorks, as described above, no extended COBRA coverage will be available to any qualified beneficiary.

Complete the following:

1. Identify Covered Employee (the employee or former employee who is or was covered under the Plan)

Name of employee _____
Address _____
City _____ State _____ Zip _____

2. Identify Initial Qualifying Event (the event that started your COBRA coverage) (Check one and complete)

Termination of employment Reduction of hours

Date of initial qualifying event _____

3. Identify All Qualified Beneficiaries: (any dependents who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now)

Name of qualified beneficiary: _____
Address of qualified beneficiary: same as employee's address listed above
 different address (provide address below)
Address _____
City _____ State _____ Zip _____

Name of qualified beneficiary: _____
Address of qualified beneficiary: same as employee's address listed above
 different address (provide address below)
Address _____
City _____ State _____ Zip _____

Name of qualified beneficiary: _____
Address of qualified beneficiary: same as employee's address listed above
 different address (provide address below)
Address _____
City _____ State _____ Zip _____

Name of qualified beneficiary: _____
Address of qualified beneficiary: same as employee's address listed above
 different address (provide address below)
Address _____
City _____ State _____ Zip _____

Name of qualified beneficiary: _____
Address of qualified beneficiary: same as employee's address listed above
 different address (provide address below)
Address _____
City _____ State _____ Zip _____

4. Identify Disabled Qualified Beneficiary

Name of disabled qualified beneficiary: _____

Address of disabled qualified beneficiary: same as employee's address listed above
 different address (provide address below)

Address _____

City _____ State _____ Zip _____

5. Social Security Administration's Determination of Disability

- Date of Social Security Administration's determination _____
You must provide a copy of the Social Security Administration's determination with this notice. Is a copy enclosed? Yes No
- Date that disabled qualified beneficiary became disabled (according to Social Security Administration determination): _____
- Has the Social Security Administration subsequently determined that the qualified beneficiary is no longer disabled? Yes No

Certification, Signature and Date:

I certify that the above information is true and correct. I am the (check one):

- employee or former employee
- spouse or former spouse
- disabled qualified beneficiary
- other (explain) _____

Signature _____ **Date** _____

Print Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

For WageWorks Use Only:

Date Notice of Disability received: _____

Date of postmark, if mailed (Attach copy of postmark) _____

Social Security Administration determination of disability enclosed? Yes No