NOTICE OF DISABILITY FORM

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Employer Name/Plan Sponsor

When to use this form:

Use this form when the Social Security administration has determined that a qualified beneficiary was disabled on any day of the first 60 days following a qualifying event that was the covered employee's termination of employment or reduction of hours. (Note: If the Social Security Administration made the disability determination before the covered employee's termination of employment or reduction of hours, you may still use this form to report the earlier disability determination, so long as the qualified beneficiary remains disabled and you provide this Notice of Disability by the deadline described below.)

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 or hand deliver this notice to:

Tri-Star Systems
Attn: COBRA DEPT.
16253 Swingley Ridge Road, Suite 210
Chesterfield, MO 63017

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.

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

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 initial notice and election notice (for 18-month qualifying events). (You may obtain copies of these documents from your former employer.

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Employer Name/Plan Sponsor

Complete This Portion:

Identify the Covered Employee (the employee or former employee who is or was covered under the Plan):
Print name of employee: _____
Address of employee: _____

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

Termination of employment

Reduction of hours

Date of initial qualifying event: _____/_____/_____

Identify All Qualified Beneficiaries:

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are still receiving COBRA coverage now:

_____

_____

Address of each qualified beneficiary: same as employee's address different address(provide address)

_____

Identify Disabled Qualified Beneficiary:

Print name of disabled qualified beneficiary: _____
Address of disabled qualified beneficiary: same as employee's address different address (provide address):

_____

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 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 former dependent child other (explain)

_____

_____

_____ _____
Signature Date

_____
Print Name

_____
Address

_____
Address

(_____) _____--_____
Telephone Number