

**REQUEST FOR
SOCIAL SECURITY DISABILITY EXTENSION**

Please Print

NAME (Last, First)	
SOCIAL SECURITY#	
PHONE NUMBER	
ADDRESS	
CITY/ST/ZIP	

**RETURN THIS FORM WITH A COPY OF YOUR
NOTICE OF AWARD LETTER FROM THE SOCIAL SECURITY
ADMINISTRATION**

Mail to:	Planned Benefit Systems, Inc. COBRA Compliance Department P.O. Box 4594 Greenwood Village, CO 80155-4594
Fax to:	303-221-2785
Email:	COBRA@pbs.us.com

If your extension is granted, your COBRA coverage will be extended an additional 11 months from your original COBRA coverage end date at a rate of 150% of the monthly premium.

Below is a list of eligibility requirements for the extension:

- Submit *Notice of Award* from the Social Security Administration to Planned Benefit Systems, Inc. within 60 days of receipt
- Disability entitlement must begin before or within first 60 days of COBRA coverage.
- Planned Benefit Systems must be notified before end of COBRA coverage.

Office Use Only: Postmark _____ Entered _____ Carrier _____