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Mercer Marketplace 365+SM

Social Security Disability Extension (SSDE) Form

This form is used to apply for or cancel a Social Security Disability Extension (SSDE).

*=Required Fields

Step 1: Qualified Beneficiary Information

*Primary Qualified Beneficiary Name (First, MI, Last)

*Social Security Number

*Previous Employer (Do not abbreviate)

*Day Telephone

Email Address

Step 2: SSDE Information

☐ Applying for an SSDE: 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 that 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 (SSDE) is granted. Additionally, I understand 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.

☐ Cancelling a SSDE: 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.

Step 3: SSDE Information

I understand my submission of this form is to either continue or cancel my coverage due to the SSDE. Further, I understand my request to extend coverage due to the SSDE does not guarantee coverage will be extended and that should my request be denied I will be notified in writing.

*Primary Qualified Beneficiary Signature

*Date

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