FORM 400

NOTICE TO COMPANY OF DISABILITY OF QUALIFIED BENEFICIARY

TO: Via Fax (724) 514-6648
Via E-Mail
linda.rall@hracobra.com or alena.loiselle@hracobra.com or sandra.stankus@hracobra.com
Human Resources America, Inc.
P.O. Box 8
Houston, PA 15342

FROM: _____ ("Client") DATE: _____

_____ Contact name

_____ Contact Telephone

DISABILITY OF QUALIFIED BENEFICIARY

Name of Employee: _____

Date of employee's termination from employment or reduction in hours resulting in ineligiblity under the Plan: _____

Name of Qualified Beneficiary determined to be disabled by the Social Security Administration: _____

Date of determination of disability by the Social Security Administration: _____

Date Qualified Beneficiary determined not to be disabled: _____

FORM 500