

**COBRA Notice:
Early Termination of COBRA Coverage**

The above listed notices were sent to the following:

| | |
|------------------------------|--|
| Date of Notice | |
| Name of Individual(s) | |
| Address | |
| City, St, Zip | |
| Notes: | |



Important Information Regarding your rights to COBRA continuation coverage.

Notice of Early Termination of COBRA Continuation Coverage

Important

This notice is being provided to inform you that your COBRA continuation of health care coverage under the health care plan or plans listed below has ceased or will cease prior to the end of the maximum period of coverage.

If any of the below listed individuals do not reside with you at the address listed on this notice, please notify the plan administrator so that a copy of this notice may be sent.

Employee Information

| | | | |
|--|--|--------------------------|--|
| Date of Termination of Coverage | | Date of Notice: | |
| Address | | Social Security # | |
| City, St, Zip | | Name of Plan: | |

Coverage will terminate for the following individuals

| | | | |
|-------------|--|---------------------|--|
| Name | | Relationship | |
| Name | | Relationship | |
| Name | | Relationship | |
| Name | | Relationship | |
| Name | | Relationship | |

Company/Contact Information:

| | | | |
|------------------------|--|---------------------------|--|
| Company Name | | Plan Administrator | |
| Company Address | | | |
| Phone | | | |

COBRA continuation coverage terminated, or will terminate, for the following reason: (check one)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Required Premium was not paid on time. |
| <input type="checkbox"/> | Individual(s) named above became covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the individual. |
| <input type="checkbox"/> | Individual(s) named above became enrolled in Medicare. |

| | | |
|--|--|--|
| | Employer terminated all group health coverage. | |
| | Individual became entitled to a 29 month maximum coverage period due to disability of a family member, and the Social Security Administration has made a final determination that the family member is no longer disabled. | |
| | For Cause”(explain) | |

If you disagree with this determination (that is, you believe that your COBRA coverage should not have been terminated), you may appeal. If you would like to appeal:

- 1) Send a written appeal to the plan administrator (listed above) within 30 days of your receipt of this notice.
- 2) Explain why you believe that your COBRA continuation coverage was improperly terminated, including all information you wish to be reviewed. Be sure to include your name, current address, and the names of any covered dependents you wish to include in your appeal.

Your appeal will be reviewed and a response will be provided within 14 days by:

(Name and title of person or committee acting on behalf of plan administrator)

If you have any questions regarding the information in this notice, please contact the plan administrator.

A certificate of creditable coverage (HIPAA certificate) may be included with this notice.