

Sample

Notice of Termination of Continuation Coverage

Date:

To: (List all eligible participants)

From: [Name of Benefits Administrator/HR Manager at your organization]

Re: Cobra Continuation/State Continuation of Group Health Plan offered by (enter Employer's name)

This notice is to inform you and your qualified beneficiaries, if any, that COBRA Continuation/State Continuation coverage under [enter employer name]'s Carrier's Name Plan will terminate [last date of COBRA].

You and your family members are entitled by a federal law known as Cobra/State Continuation to continue the same health coverage you elected under (Carrier's Name) benefits for up to eighteen (18) months beginning on (enter date coverage begins).

If any of your qualified beneficiaries do not reside with you at your address, please notify [enter name and phone number of Benefits Administrator] immediately so that a copy of this notice can be sent to those individuals as well.

In order to maintain continuation coverage under the plan, each person must meet the following conditions:

- You must elect continuation coverage within sixty (60) days of the loss of coverage date.
- You must make timely payments as described on the election form.
- You are not covered by any other group health plan or entitled to Medicare Benefits, provided that the other coverage does not contain an exclusion or limitation due to pre-existing limitations.

If you have any questions regarding the information in this notice, please contact [enter name address and phone number of Benefits Administrator].

Sincerely,