Notice of Termination of COBRA Continuation Coverage

This is a notice that COBRA continuation of health care coverage under the _____ will end on _____ for the following individuals:

_____

_____

_____

_____

_____

_____

If these individuals don't live with you at the above address, please let the plan administrator know so we can provide them with a copy of this notice. The plan administrator's name and contact information are at the end of this notice.

COBRA continuation coverage is ending before the expiration of the maximum period because:

- ☐ The premium was not paid on time or during the grace period.
- ☐ The individual(s) above became covered under another group health plan that doesn't deny coverage to people who have a serious ongoing health condition.
- ☐ The individual(s) above became enrolled in Medicare.
- ☐ The employer stopped group employee health plan coverage.
- ☐ The individual(s) above were entitled to a 29-month maximum coverage period due to disability of a family member and the Social Security Administration determined that the family member is no longer disabled.
- ☐ For cause: _____.

Under the plan, the individual(s) named above have the right to enroll in an individual conversion health insurance policy without providing proof of insurability. There's a time period for enrolling in this policy. Contact the plan administrator for more information or to enroll.

Plan administrator: _____

Contact: _____

Address: _____

_____

_____

Phone number: _____