# COBRA: Termination of Coverage Notice

Red text denotes a field that needs to be changed by the user.

[Date]

[Name]  
[Street Address]  
[City, State ZIP]

This notice pertains to your COBRA continuation coverage under [Name of the plan(s) under which COBRA coverage will terminate]. It is important that all covered individuals read this notice. Please advise [Name of COBRA administrator] immediately if there is a covered dependent not living at the above address.

**Coverage under the plan(s) named above ceased or will cease on [last day of coverage] for the following individuals:** [Insert name(s) of qualified benefactors who are losing coverage]

**COBRA continuation coverage terminated or will terminate for the following reason:**

A required premium was not paid in full on time.

A qualified beneficiary became covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary.

A covered employee became entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage.

The employer ceased to provide any group health plan for its employees.

For cause (e.g. fraud): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Describe any rights the qualified beneficiary may have to elect alternative group or individual coverage, such as a conversion right.]

**If you believe that your COBRA coverage should not have been terminated, you can request us to reconsider our determination by filing an appeal as follows:**

1. Send a written appeal to [Name and Address] within 30 days of your receipt of this notice.
2. Explain why you believe your COBRA continuation coverage was improperly terminated and include 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.

**If you have any questions regarding the information in this notice, you should contact:**

[Name of COBRA administrator, Telephone Number and Address].

Sincerely,

[Signature]

[Name and Position Title]

## Note to Employer

#### Regarding the Notice of Termination of Continuation Coverage

A plan administrator must notify any qualified beneficiary whose COBRA coverage terminates before the end of the maximum COBRA period. To comply with this rule, a plan administrator must ensure that this notice contains required information and must deliver the notice in a timely manner to the appropriate individual(s).

#### Required content and form

The notice must explain the reason coverage has terminated, provide the date of termination and describe any rights the qualified beneficiary may have to elect alternative group or individual coverage, such as a conversion right (29 C.F.R. 2590.606-4(d)).

A plan administrator may furnish this notice of early termination within the same document as the certificate of creditable coverage that the plan is otherwise required to furnish (pursuant to HIPAA) to a participant whose health coverage is terminating.

#### Timing

The time for providing this notice is as soon as reasonably practicable following the plan administrator’s determination that continuation coverage will terminate (69 Fed. Reg. 30090). Although the lack of a specific date appears to offer plan administrators some flexibility, delay in providing this notice should be avoided to minimize potential adverse consequences, such as having to pay statutory penalties or provide coverage to ineligible individuals.

#### Required recipients

A plan administrator must provide notice to each qualified beneficiary whose continuation coverage terminates earlier than the maximum COBRA period.

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