To: {**Name of COBRA Qualified Beneficiary EE**}

 {**Name of COBRA Qualified Beneficiary Spouse**} and all covered dependents

 **{Address of COBRA Qualified Beneficiary}**

Date:{**Date of COBRA Letter**}

Loss of Coverage Date: **{Date coverage is canceled}**

**Re: Important notice regarding loss of your health insurance coverage and the**

 ***unavailability* of group health insurance continuation coverage rights**

Please be advised that as of **{Date coverage is canceled},** your group health, dental, or vision insurance; health FSA coverage; or HRA coverage (collectively “group health plan”) ended under the **{Employer name}** group health plan for the following reason:

Qualifying Event: **{Enter Qualifying Event}**

Date of Qualifying Event: **{Enter Date of Qualifying Event}**

If a medical provider (hospital, physician or pharmacy) calls to verify benefits for medical services after the loss of coverage date, they will be advised that you are no longer a participant under the plan, therefore any payment for health plan services will be denied and will be your responsibility.

**No Group Health Plan Continuation Coverage Rights (COBRA):** The above event and loss of coverage would normally result in you having the opportunity to continue your group health insurance at your own expense under the federal COBRA law. However, this federal protection is ***not available*** to you for the following reason:

As described in your summary plan description and the COBRA initial notification you received upon first becoming covered by the plan, you were, by plan rule and COBRA law, to make notification within 60 days after the qualifying event occured (or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later). We did not receive notice of the above event until **{Date participant provided notice of event}.** Since notification was not made within the required timeline, your COBRA rights have been lost.

**Appeals Procedure:** If you wish to appeal this decision, please send a written request to **{Employer contact}** (address is shown below). Please include your name, address, social security number and date of birth. Please submit proof that timely notification was made to {**Employer Name}.** Include all information you wish to be reviewed, as well as the names of any qualified beneficiaries, such as your spouse or child(ren) covered by your appeal.Appeals must be received within 30 days of this letter.

**Questions:**

Should you have any questions regarding this notice, please contact **{employer contact},** at **{employer contact phone number},** Human Resources **{Employer Name}, {Employer Address}**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***