**{Date of COBRA Letter}**

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

**{Address of COBRA Qualified Beneficiary}**

***RE: Notification of Loss of Group Health Plan Coverage***

Please be advised that you are no longer covered under the group health plan maintained by **{Employer Name}**. Your **{health} {dental} {vision} {health FSA} {HRA} {Other group health plan subject to COBRA}** coverage was canceled by the employee, which the plan allows him/her to do. Your last day of coverage under the plan was **{date coverage was canceled}**. Any medical expenses occurring after that date will not considered a covered expense. If a health care provider (hospital, physician or pharmacy) calls for verification of benefits, they will be advised that you are no longer a covered participant under the plan.

**Potential Group Health Insurance Continuation Rights**

Federal COBRA law allows, in certain qualifying event situations, that covered dependents who lose their group health plan coverage to continue coverage for a period of time at their own expense. Your loss of group health plan coverage, however, does **not** qualify you for this continuation of health insurance coverage under COBRA. Your loss of the group health plan coverage referenced above was a voluntary decision made by the employee.

However, if the employee canceled your group health plan coverage because of a divorce/legal separation or because a dependent is no longer eligible for coverage under plan provisions, then COBRA rights may be available. If this is the case, you must notify the plan administrator immediately by calling **{employer contact phone number}** to determine your eligibility for COBRA. Failure on your part to notify the plan administrator of a divorce/legal separation or a dependent ceasing to be a dependent under the terms of the plan within 60 days of the qualifying event or from the loss of coverage date will result in a loss of any potential COBRA rights you may have had.

**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.***