**Early Cancellation of COBRA Coverage**

**{Date of COBRA Letter}**

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

**{Address of COBRA Qualified Beneficiary}**

***RE: Notice of Your Early Cancellation of COBRA Continuation Coverage***

This notice is being sent to inform you **{Employer Name}** is terminating your COBRA coverage for health, dental, vision, health FSA and/or HRA coverage prior to the end of your maximum continuation coverage period. Effective **{date coverage is canceled},** your coverage is being canceled for the following reason:

🞎 Failure to remit premium within the 30 day grace period.

🞎 {**Employer Name}** has ceased to provide any group plan.

🞎 **{Employer Name}** was notified you are covered under another plan.

🞎 You have become entitled to Medicare.

🞎 Per your request to cancel coverage.

🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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.***