**{Date of COBRA Letter}**

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

**{Address of COBRA Qualified Beneficiary}**

# RE: NOTICE OF SECOND QUALIFYING EVENT RIGHTS

Since **{Date of Qualifying Event}** you have been insured under **{Employer Name}**’s group health, dental, vision insurance, or HRA plan under the rights provided you by the federal COBRA law. Your first event under COBRA allowed you to continue coverage for 18 months. Your last day of coverage would have been **{Date coverage expired}.**

**Notification of *Second* COBRA Qualifying Event**

However, this letter is to acknowledge receipt of your notification that a second COBRA qualifying event occurred on **{date of second event} i**ndicated by the check mark below:

\_\_\_\_\_ Death of employee

\_\_\_\_\_ Medicare entitlement of employee

\_\_\_\_\_ Divorce/legal separation from employee

\_\_\_\_\_ Dependent child ceasing to be a dependent under terms of the policy

This second qualifying event allows you to extend your COBRA continuation of coverage period to **{date coverage expires after second event},** a total of 36 months from your first qualifying event. This opportunity to extend your coverage is being granted to you due to a provision in the Federal law which allows COBRA beneficiaries to extend their COBRA coverage period when they experience certain qualifying events during their period of COBRA coverage. In order to take advantage of this offer to extend your coverage, you must only continue to make timely premium payments until the aforementioned time period has expired.

**This offer assumes you remain eligible for COBRA coverage:** Please remember your COBRA coverage will be canceled prior to the aforementioned date if you fail to make timely premium payments, we cease to maintain any group health plans, you become entitled to Medicare benefits or you become covered under any other group health plan.

**{Insert paragraph if premium will be adjusted}**

**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.***

***.***