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[Date]

[Employee Name]

[Employee Address]

Dear Employee and Covered Dependents:

This notice is intended to summarize your rights and obligations under the group health continuation coverage provision of COBRA. You and your spouse should take the time to read this notice carefully. Should you qualify for COBRA coverage in the future, the group health plan administrator or plan sponsor will send you the appropriate notification.

Federal law requires [Name of Employer] to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

TO QUALIFY FOR COBRA COVERAGE

Employees. As an employee of [Name of Employer] covered by [Group Health Plan Name], you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Retirees. As a retiree, spouse of a retiree, or dependent child of a retiree, of [Name of Employer] covered by [Group Health Plan Name] you have the right to elect this continuation coverage if you lose your group health coverage because [Name of Employer] declares Chapter 11 bankruptcy and you lose your group health care coverage within one year before or after the bankruptcy proceedings.

Spouses. As the spouse of an employee covered by [Group Health Plan Name], you have the right to choose continuation coverage for yourself if you lose group health coverage under [Group Health Plan Name] for any of the following reasons:

- The death of your spouse who was an employee of [Name of Employer]
- A termination of your spouse's employment (for reasons other than gross misconduct)
- A reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

Dependent Children. In the case of a dependent child of an employee covered by [Name of Group Health Plan], he or she has the right to continuation coverage if group health coverage under [Name of Group Health Plan] is lost for any of the following reasons:

- The death of a parent who was an employee of [Name of Employer]
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with [Name of Employer]
- Parent's divorce or legal separation
- A parent who was an employee of [Name of Employer] becomes entitled to Medicare
- The dependent ceases to be a "dependent child" under [Name of Group Health Plan].

YOUR NOTICE OBLIGATIONS

Under the law, the employee or a family member has 60 days from (1) the date of the event or (2) the date on which coverage would be lost, whichever is later, to inform [Name and Address of Plan Administrator] of the employee's divorce or legal separation, or of the employee's child losing dependent status under [Name of Group Health Plan]. Please give notice in the following manner: [specify if you want the person to call you, write to you, etc.]

Failure to give notice within the time limits can result in COBRA coverage being forfeited.

[Name of Employer] has the responsibility to notify [Name of Plan Administrator] of the employee's death, termination of employment, reduction in hours, or Medicare entitlement.

TO ELECT COVERAGE

When [Name of Plan Administrator] is notified that one of these events has happened, [Name of Plan Administrator] will in turn notify the employee, spouse and dependents that they have the right to choose COBRA continuation coverage. The employee and spouse have independent election rights. The employee, spouse and dependents have 60 days from either (1) the date coverage is lost under [Name of Group Health Plan] or (2) the date of the notice, whichever is later, to respond informing [Name of Plan Administrator] that they want to elect continuation coverage. There is no extension of the election period.

If an employee, spouse or dependent does not elect continuation coverage within this election period, then rights to continue group health insurance will end.

If an employee, spouse or dependent chooses continuation coverage and pays the applicable premium, [Name of Employer] is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees or family members. If [Name of Employer] changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

DURATION OF COBRA COVERAGE