Notice of Denial / Unavailability of COBRA Coverage

_____
[Name of plan]

_____
[Name of plan sponsor]

_____
[Date of notice]

To _____
[Name of Ineligible party]

You are receiving this notice because you recently made a request for COBRA continuation coverage under the following health plan: _____. However, you are not entitled to COBRA coverage for the following reason(s):
[Name of health plan]

[ ] Unavailability of COBRA Coverage

[ ] COBRA continuation is not available

[ ] The health plan has been terminated as of _____
[Date plans were terminated]

[ ] Ineligibility for COBRA Continuation Coverage

The COBRA administrator has determined that you are not eligible for COBRA continuation coverage due to the following:

_____

_____

_____

If you have any questions about this notice or COBRA continuation coverage in general, please contact the health plan administrator at the address and telephone number listed below.

_____ _____
[Name] [Address]

_____ _____
[Phone] [City, State, Zip Code]