Notice of Early Termination of COBRA Coverage

_____
[Name of plan]

_____
[Name of plan sponsor]

_____
[Date of notice]

To _____
[Name of qualified beneficiary]

You are receiving this notice because your COBRA continuation coverage under the following health plan has terminated / will terminate on _____/_____/_____ for the following reason:
[Date]

[ ] Failure to pay the required premium within 31 days of the due date.

Your last payment was due _____/_____/_____ .
[Payment due date]

[ ] Your Medicare entitlement commenced on _____/_____/_____.
[Date of medicare commencement]

[ ] You became entitled to coverage under another group health plan on _____/_____/_____ .
[Commencement date of new coverage]

[ ] We have terminated all group health care plans as of _____/_____/_____ .
[Date plans were terminated]

Right to Select Other Coverage

[ ] You do not have rights to other coverage.

[ ] You have rights to other coverage as listed below.

_____

_____

If you have any questions about this notice or COBRA continuation coverage, please contact the COBRA Administrator.

_____ _____
[Name] [Address]

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