Notice of Unavailability of COBRA Continuation Coverage

Date of Notice: ______________________________

To: ______________________________

(Address): ______________________________

(City, ST, ZIP): ______________________________

From: _________________________

(Address): _________________________

(Telephone Number): _________________________

On ___________________________, the Plan Administrator of the ______________________________________(the Plan) received a notice indicating the following information (check appropriate box):

Notice of Event:

- Divorce from covered employee
- Legal Separation from covered employee
- Cessation of dependent child status under the Plan

Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the event listed above could entitle an employee's spouse and his/her dependent child(ren), if any applicable, to elect COBRA continuation coverage under the Plan for up to 36 months from the date of that event, but ***only if*** the event is a "qualifying event." An event is a COBRA qualifying event in this case only when it causes the covered spouse and/or the covered dependent child(ren) to lose coverage under the Plan AND when the Plan Administrator (the plan sponsor) was notified of the event in accordance with the notice procedures established by the Plan for notifying the Plan Administrator of the event.

COBRA Continuation Coverage Unavailable

The Plan Administrator has determined that, in this case, COBRA continuation coverage is not available to ____ and the event identified above is not a qualifying event for COBRA purposes because (check appropriate box):

- Plan was not notified within 60 days of the event.
- Plan was not notified within 60 days of loss of coverage.
- The person for whom COBRA is being requested in not covered under the Plan and therefore is not eligible for COBRA.
- The event submitted does not cause a loss of coverage under the Plan.

Therefore, ____, is/are determined to be ineligible for COBRA coverage and coverage under the Plan will terminate effective ______________________________.

Procedure for Review of Coverage Denial

If you believe that your rights to continuation coverage have been improperly denied, you may request a review of the plan administrator's decision. Please submit your appeal in writing to:

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For More Information

If you have any questions about this notice, please contact the Plan Administrator at the address noted above or by telephone at ___________________________.