At the time of publication, a model of the following notice had not been provided in or as an appendix to any governmental regulations. Regence BlueCross BlueShield of Utah has prepared this sample to assist employers and plan administrators in the drafting of their own notices, but makes no representation regarding the acceptability or sufficiency of this sample. Regence BlueCross BlueShield of Utah does not assume responsibility for updating these materials as changes in the law, rules, regulations, and interpretations occur, nor does it assume responsibility or liability for decisions or actions made in reliance on this material. This material is not intended to supply legal advice or solve individual problems. Such advice and solutions should be sought through consultation with an attorney.

SAMPLE
NOTICE OF TERMINATION OF COBRA CONTINUATION COVERAGE

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies) by name or status*]

This notice is provided to inform you that your COBRA continuation coverage terminated or will terminate as of [*enter date*] due to [*check appropriate box*]:

- ❑ Failure to make payment of premium for continuation coverage on time or within applicable grace periods.
- ❑ [*Employer's name*]'s (and all companies within its control group's) no longer providing group health coverage to any of its (or their) employees.
- ❑ Your becoming covered, after electing this COBRA continuation coverage, by another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition that you have.
- ❑ Your becoming entitled to Medicare benefits, after electing this COBRA continuation coverage.
- ❑ The final determination of the Social Security Administration that the disability by which you had extended COBRA continuation coverage no longer disables the formerly disabled individual.
- ❑ An event that would be cause for termination of coverage of a participant or beneficiary who was not receiving continuation coverage (e.g., fraud).
- ❑ Other:
  ____
  ____
  ____

If you have questions about this notice and its determination that your COBRA continuation coverage will terminate prior to the maximum COBRA continuation period, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].