

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[Enter date of notice]

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

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [enter date] due to [check appropriate box]:

- | | |
|--------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of dependent child status |

Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on [enter date] and can last until [enter date]. [Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].

COBRA continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].