Federal COBRA Coverage Termination Notice Example Only

[Company Letterhead]

[Insert Date]

[Participant Name]
[Last Known Address]
[City, State & Zip Code]

RE: Termination of Group Health Insurance Continuation Coverage (COBRA)

Please be advised that as of _____ **[Effective Date]** your group health insurance continuation coverage ended for the following reason:

☐ We as the employer have ceased to provide any group health plan.

☐ Timely premium payment for your group health insurance continuation coverage (COBRA) was not made within the maximum 30-day grace period.

☐ You have become covered under another group health plan (as an employee or otherwise).

☐ You have become entitled to Medicare.

☐ You have requested that your group health insurance continuation coverage be terminated.

☐ You have reached the maximum coverage continuation period.

Should you have any questions regarding this notice, please contact us at _____ **[Enter Company Contact Information]**.

Sincerely,

[Your Name]
[Your Title]