COBRA Continuation Coverage Notice

Date: ____________________
Employee Name: ____________________
Employee Address: ____________________

Introduction

This notice includes important information about your right to continue your group health coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) after your employment ends or other qualifying event occurs.

Qualifying Event

According to our records, the following qualifying event has occurred:

- Type of Event: ____________________
- Date of Event: ____________________

Your Rights

As a result, you are entitled to elect continuation of your health coverage for yourself and your eligible dependents for a limited period of time, typically up to 18 or 36 months, depending on the nature of the qualifying event.

Coverage and Premiums

You must pay the full cost of coverage, plus a 2% administrative fee. Premium rates, coverage options, and payment instructions are outlined in the attached materials.

How to Elect Continuation Coverage

To continue your coverage, you must complete and return the election form included with this notice by the election deadline:

- Election Deadline: ____________________
- Return Form To: ____________________

For More Information

If you have questions regarding your COBRA rights or this notice, contact:

- COBRA Administrator: ____________________
- Phone: ____________________
- Email: ____________________

You may also refer to the Department of Labor's website for additional information on COBRA coverage.

Sincerely,