NOTICE OF UNAVAILABILITY FOR COBRA CONTINUATION COVERAGE

INSTRUCTION SHEET (E14)

RECIPIENTS: An individual who notifies the Plan Administrator of a qualifying event, second qualifying event, or Social Security disability determination must be notified if he/she is not eligible for COBRA.

DEADLINE DATE: Within 14 days from the date the individual notifies the Plan Administrator of the qualifying event.

DELIVERY: It is recommended that the notice be mailed certified receipt or registered receipt so that there is proof that it was sent.

FORM COMPLETION: The Plan Administrator completes the entire form.

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Date of Notice:

Our records indicate that the individuals listed below are - or were - participants in the organization's group health plan(s):

Employee Name:

Name of Spouse or Former Spouse (if applicable):

Names of Dependent Children (if applicable):

And that the following qualifying event has occurred:

- ☐ Employee's separation of employment
- ☐ Employee's reduction in work hours
- ☐ Death of employee
- ☐ Divorce or legal separation
- ☐ Employee's enrollment in Medicare
- ☐ Dependent ceasing to qualify for coverage under the Plan

Date of Qualifying Event: _____

The participant(s) listed below is/are not eligible to elect COBRA continuation coverage under the following group health plan(s):

☐ medical insurance ☐ dental insurance ☐ medical flexible spending account ☐ Other _____

- ☐ Employee
- ☐ Spouse or Former Spouse
- ☐ Dependent Child/Children _____

(List each applicable dependent's name)

Reason for Denial of COBRA Continuation Coverage:

- ☐ No qualifying event has occurred
- ☐ The individual is not a qualified beneficiary
- ☐ The individual was not covered under the Plan on the day before the qualifying event
- ☐ Failure to provide timely notification to the Plan Administrator of a qualifying event
- ☐ Failure to submit the *COBRA Continuation Coverage Election Notice Form* by the due date
- ☐ Other _____

(Please Specify)

If you have any questions, please contact the Plan Administrator at the following address and telephone number:

Name of Plan Administrator: _____ Telephone #: _____

Address: _____