ATTACHMENT D

-DEPARTMENT LETTERHEAD-

SAMPLE
NOTICE OF UNAVAILABILITY OF CONTINUATION COVERAGE

Date of Notice: **(Current Date)**

Sam and Lisa Johnson, and all covered dependents (if any)
Mailing Address
City, State, Zip Code

RE: NOTICE OF UNAVAILABILITY OF CONTINUATION COVERAGE

It is important that all covered individuals read this notice. Notification to the covered spouse or domestic partner is deemed notification to any covered dependent children. In addition, if there is a covered dependent not living at the above address, please provide the Personnel Office with the appropriate address in order that a notice can be sent to him/her as well.

No COBRA Group Coverage(s) Continuation Rights

Effective on **(date coverage(s) cease)**, you are no longer covered under the State-sponsored **(coverage plan name)** plan. This means a claim for services occurring on or after this date will not be paid. Your loss of coverage is resulting from a **(event)** on **(event date)**. The above event and loss of coverage would normally result in you having the opportunity to continue your State-sponsored **(coverage plan name)** plan under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). However, the right to elect COBRA continuation is not available to you for the following reason:

As indicated in the Initial General COBRA Notice which you received when you first became covered by the plan(s), you were required to make notification to the Personnel Office within 60 days from the date of the qualifying event or the date on which coverage is lost. Notification to the Personnel Office was not made within the required timeline, therefore, your COBRA rights have been lost.

Questions/Appeal - If any covered individual has questions regarding this notice or wish to appeal the decision not to offer you COBRA continuation coverage, please contact the Personnel Office at **(phone number, address, and name of department representative)** for assistance.