ATTACHMENT K

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

<name of dependent(s) loosing coverage>,
Mailing Address
City, State, Zip Code

RE: NOTICE OF LOSS OF EMPLOYER SPONSORED COVERAGE

It is important that you as a person covered person(s) under the State's dental plan read this notice. Notification to the covered spouse or domestic partner is deemed notification to any covered dependent children living at the same address (including any dependent children covered in the future). 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 that person as well if they are now losing coverage.

Loss of Group Coverage(s) and Qualifying Event
Effective on **(date coverage(s) cease)**, you will no longer be covered under the State-sponsored **(coverage plan name)** dental plan. This means a claim for services occurring on or after this date will not be paid. Your loss of coverage is resulting from the employee deleting you on the basis of a **move out of household event on (event date)**. However, the right to elect COBRA continuation is not available to you because the employee deleted dependent coverage based on this event. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), this **does not** constitute a "qualifying event" which allows all covered individuals (also known as qualified beneficiaries) the right to continue coverage for a period of time after **(date coverage ceases)** for **(36 months)**.

Questions - If any covered individual effected by this action has questions regarding this matter, please contact the Personnel Office at **(phone number, address, and name of department representative)** for assistance.