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COBRA CONTINUATION COVERAGE TERMINATION AND CONVERSION RIGHTS FORM

Date: _____

QUALIFIED BENEFICIARY INFORMATION

First Name M.I. Last Name Social Security #

Home Address City State Zip Code

Date of Birth Marital Status

of Dependent Children Date of Hire

Policy Number

Effective _____, COBRA coverage will terminate for the following individuals:

<u>Name</u>	<u>Relationship</u>	<u>Policy #</u>	<u>Type of Coverage</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REASON FOR TERMINATING COBRA COVERAGE

_____ Coverage under another group health plan does not limit or exclude pre-existing conditions.

_____ Completion of COBRA Continuation Coverage.

_____ 18 months

_____ 29 months

_____ 36 months

_____ Failure to pay required premium on time.

_____ Termination of all Company group health plans.

_____ Other _____

CONVERSION RIGHTS TO INDIVIDUAL HEALTH INSURANCE POLICY

You may have the right to convert your group health benefits under COBRA to an individual health insurance policy. The Plan Administrator can provide you eligibility information, enrollment forms and other information on your conversion rights. If you qualify for the conversion policy, you will have _____ days to submit your insurance application and first premium once your COBRA coverage ends.

APPEAL PROCEDURE

Please notify the Plan Administrator as soon as possible if you believe the termination date of your COBRA coverage is inaccurate. You may request a review of this decision.

Please contact the Plan Administrator as soon as possible if you have questions about this notice or your COBRA rights.