# Sample Notice of Unavailability of COBRA Continuation Coverage

[*Date*]

To: [*Name of Applicant*]

[*Address*]

[*City, State, Zip*]

We have received your notice requesting COBRA continuation coverage or an extension of COBRA continuation coverage through the following Group Health Care Plan:

[*Name of Plan*]

Your request is based upon (check all that apply):

* Your divorce or legal separation from a covered employee under the plan
* Your loss of status as an eligible dependent child under the plan
* Voluntary or involuntary termination of employment for reasons other than gross misconduct
* Reduction in the number of hours of employment
* Death of the covered employee
* You and/or your dependents who are qualified beneficiaries and are currently receiving COBRA continuation coverage have experienced a second qualifying event
* You or a qualified beneficiary currently receiving COBRA continuation coverage have become disabled
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We have determined that you and/or your qualified beneficiary dependent(s) do not qualify for COBRA continuation coverage or for an extension of COBRA continuation coverage for the following reason(s) (check all that apply):

* No qualifying event as defined by law has occurred.
* You and/or your dependents were not covered under the plan on the day before the qualifying event.
* You and/or your dependents did not provide notice of your divorce, legal separation, or loss of dependent child status within \_\_\_ days of the event, as required under the plan.
* The circumstances you have described do not constitute a "second qualifying event" under COBRA.
* You and/or your eligible dependents did not provide timely notice of the determination of disability by the Social Security Administration as required by the plan.
* The Social Security Administration has determined that you are not disabled, or, if you were disabled, you are no longer disabled.
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you have any questions about this determination, please contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

***Plan Administrator Note:*** *There are* [*two circumstances*](http://www.dol.gov/ebsa/publications/cobraemployer.html#DurationofContinuationCoverage) *in which individuals who are entitled to an 18-month maximum period of COBRA can become entitled to an extension of continuation coverage–-when a second qualifying event occurs (allowing an extension of up to 18 months) or when a qualified beneficiary is determined by the Social Security Administration to be disabled (allowing an extension of up to 11 months).*

*Your plan rules should describe the notice required in either instance for the qualified beneficiary to extend COBRA. A plan may set a time limit for providing notice, but the time limit cannot be shorter than 60 days, starting from the latest of (1) the date on which the qualifying event occurs; (2) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; (3) the date on which the qualified beneficiary is informed, through the furnishing of the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so; or (4), in the case of an extension due to a disability determination, the date on which the Social Security Administration issues the disability determination.*