

NOTICE OF EARLY TERMINATION OF COBRA COVERAGE

____ ("Employer")

()

To: _____

From: _____, acting on behalf of _____
_____ ("Plan Administrator"), the plan administrator for the Welfare Benefit Plan ("Plan")

Date: _____, 20__

Re: Notice of Early Termination of COBRA Coverage

This is notice that Federal COBRA coverage for (list types of benefit(s) affected): _____
_____ benefits under the Plan terminated/will terminate on
_____, 20__ for the following individual(s) (list names of qualified beneficiaries):

COBRA coverage is terminating before the maximum period of coverage ends, for the following reason:

- [] Required premium was not paid on time
[] Employer ceased to provide any [] medical [] dental [] vision group health plan benefits for its employees
[] Individual(s) named above became covered under another [] medical [] dental [] vision group health plan benefits that does not impose any preexisting condition exclusion for a preexisting condition of the individual(s)
[] Individual(s) named above became entitled to a 29-month maximum coverage period due to disability of a family member, and the Social Security Administration has made a final determination that the family member is no longer disabled
[] Individual(s) named above became enrolled in Medicare [] For cause: _____

Claims incurred after the termination date shown above may have been paid on behalf of the individual(s) named above, and premiums may have been paid for COBRA coverage for periods after the termination date. If that is the case, premiums for periods after the termination date will be refunded, and reimbursement of benefits paid for claims incurred after the termination date will be required. Premiums will be refunded only after all required reimbursements of benefits have been received.

[] (Check and complete if benefits are insured and subject to conversion rights): For insured medical benefits under the Plan, the individual(s) named above may have the right to enroll in an individual conversion health medical insurance policy, without providing proof of insurability. There is a limited time period for enrolling in a policy.

Contact, as applicable, Blue Cross Blue Shield of Wisconsin at P.O. Box 10888, Green Bay, WI 54307-0888, 1-800-499-7520 or CompCare Health Services Insurance Corporation (commonly known as CompCareBlue) at P.O. Box 10888, Green Bay, WI 54307-0888, 1-800-860-4885 to enroll.

If any of the individuals named above does not reside with you at the above address, we request that you immediately notify the Plan Administrator, in care of the Employer, at the address and telephone number above, so that we may provide a copy of this Notice to those individuals.

If you have any questions regarding the information in this Notice, you should contact the Plan Administrator, in care of the Employer, at the above address.

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