

**APPENDIX TO § 2590.606-4**  
**MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE**  
**(For use by single-employer group health plans)**

[Enter date of notice]

Dear: [Enter Name of Employee,  
Spouse, Dependent Children, as appropriate]

**This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan).**

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].

If you do not elect to continue your health care coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on [enter date] due to:

- |   |   |
|---|---|
| <input type="checkbox"/> End of employment      | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee      | <input type="checkbox"/> Divorce or legal separation      |
| <input type="checkbox"/> Enrollment in Medicare | <input type="checkbox"/> Loss of dependent child status   |

Each of the following persons is entitled to elect to continue health care coverage under the Plan:

- ☐ Employee – [enter name]
- ☐ Spouse (or former spouse of employee) [enter name]
- ☐ Dependent children [enter name(s)]

Because of the event (checked above) that will end your coverage under the Plan, you [and/or, as appropriate, your spouse, and dependent children] are entitled to continue your health care coverage for up to \_\_\_\_\_ months [enter 18 or 36 months as appropriate]. If you elect to continue your coverage under the Plan, your continuation coverage will begin on [enter date] and can last until [enter date].

Your continuation coverage will cost: [enter amount each qualified beneficiary would be required to pay for each option per month of coverage and any other permitted coverage periods.]

**IMPORTANT - To elect continuation coverage you MUST complete the enclosed "Election Form" and return it to us. You may mail it to the address shown on the Election Form [or describe other acceptable means of submission]. The completed Election Form must be post-marked by [enter date] [or received by [enter date] if submitted by other means]. If you do not submit a completed Election Form by this date, you will lose your right to elect**