NECA-IBEW WELFARE TRUST FUND

NOTICE OF INELIGIBILITY FOR COBRA CONTINUATION COVERAGE

Date__________________________

Names of all individuals
losing coverage (member,
spouse and/or children)
Street Address
City, State, Zip Code

Dear ______________________________:

This letter is to inform you that you are ineligible for COBRA Continuation Coverage under the NECA-IBEW Welfare Trust Fund because *____.

Please do not file any claim(s) for benefits incurred on or after __________________. Any such claim(s) will be returned to you unpaid.

A Certificate of Group Plan Coverage is included with this letter. This certificate will show a new health plan how long you were covered under this Plan in order to reduce or avoid the new plan's pre-existing coverage exclusion, if applicable. Call the Fund Office at (800) 765-4239, if you need to provide a form to your new health plan that shows the general categories of medical benefits provided by this Plan.

Sincerely,

____

**Insert one of the following:*

1. The Fund Office did not receive notice of the member's divorce or legal separation within 60 days of the date you lost eligibility under the plan.

2. The Fund Office did not receive notice that you, as a dependent child, had lost "dependent" status under the Plan, within 60 days of the date you lost eligibility.

1. Your election form was not received within 60 days of the later of: a) the date you lost eligibility, or b) the date you received the election form.

2. The initial payment for each full calendar month since you lost eligibility was not received within 45 days from the date the Fund Office received your election.