

NECA-IBEW WELFARE TRUST FUND
NOTICE OF TERMINATION OF 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 COBRA continuation coverage under the NECA-IBEW Welfare Trust Fund will terminate on _____ because *_____. Once terminated, COBRA cannot be reinstated under the Plan.

Any claims incurred on or after the date your COBRA terminates will be returned to you unpaid. Any claims incurred prior to this date should be filed immediately for processing.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends. Additional information about special enrollment is available from the Fund or your spouse's employer.

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 to help reduce or avoid the new plan's preexisting coverage exclusion, if applicable. If you need to provide a form to your new health plan that shows the general categories of medical benefits provided by this Plan, or if you have any questions, contact the NECA-IBEW Welfare Trust Fund Office, 2120 Hubbard Ave., Decatur, Illinois 62526-2871 or call her at (800) 765-4239.

Sincerely,

**Insert one of the following:*

1. You enrolled in Medicare after the effective date of your COBRA. However, if the member has any dependents who are entitled to COBRA, their COBRA coverage will remain in effect until the end of the 36-month period.
2. You became covered under another group health plan after the effective date of your COBRA. However, if you or one of your dependents has a health problem that is excluded from or limited as to coverage under the new group health plan, you must be allowed to continue your COBRA under the Plan until the earlier of when the condition is no longer limited or excluded under the new plan or you have had a total of 36 months of COBRA. Contact the Fund Office if these circumstances apply to you.
3. The applicable premium was not paid.
4. The maximum 36-month period for COBRA has expired.