NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE
(Explanation)

This is a letter that notifies a participant and/or beneficiary on COBRA continuation coverage that his or her coverage will be terminating earlier than the end of the maximum coverage period of COBRA coverage applicable to a qualifying event.

It should be sent as soon as practicable following the Plan Administrator's determination that continuation coverage will terminate (and preferably prior to the date of coverage termination)

This notice may be mailed in the same envelope with a HIPAA Certificate of Creditable Coverage.

[FUND/PLAN LETTERHEAD]

[Notice of Early Termination of COBRA Continuation Coverage]

Date:

_____
_____
_____

Dear _____:

Our records indicate that effective the first day of _____, 200__ you [and your spouse and/or Eligible Dependents] will no longer be eligible for COBRA continuation coverage from the Connecticut Carpenters Health Fund (the "Plan") for the following reason:

(Check one)

[ ] (a) You failed to send in your required monthly payment of $_____ for the month of _____ by the last day of that month.

[ ] (b) You became covered under another group health plan either as an employee or the dependent of an employee and we have no records that indicate that the new group health plan contains any preexisting condition exclusion that would apply to you or your dependents(s). Please contact the Fund Office if you have a pre-existing condition that is not covered by the other plan.

[ ] (c) You enrolled in any part of Medicare.

[ ] (d) You incurred a "Termination for Cause" by _____ [describe non-union employment or fraud].

[ ] (e) Your coverage was extended due to disability and the Social Security Administration determined you are no longer disabled.

[ ] (f) The Plan no longer provides group health coverage.

[ ] (g) Other: _____

Claims incurred on or after the date your COBRA continuation coverage terminates (see date above) will not be paid by the Plan. Any claims incurred prior to this date should be filed immediately for processing.

You and your Eligible Dependents are not eligible for conversion to coverage under an individual policy because such coverage is not available under this Plan.

You have special enrollment rights under federal law. You have the right to request special enrollment in another group 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 in your summary plan description or from Ms. Deborah L. Palmieri, Health Fund Administrator.

If item (c) is checked, your spouse and dependents will still be entitled to COBRA continuation coverage for ___ months.

Deborah L. Palmieri
Health Fund Administrator