**LATE COBRA PAYMENT TERMINATION WARNING LETTER**

Re: COBRA Premium Payment

Date: [today’s date]

Dear [COBRA beneficiary name],

According to our records, you elected COBRA continuation coverage for the [INSERT PLAN NAME(S) (SELECT AS APPLICABLE [HEALTH COVERAGE] [DENTAL COVERAGE] [VISION COVERAGE])] beginning [date]. As stated on the election form you submitted (copy enclosed), you are required to make periodic payments in full for each COBRA coverage period. Although these periodic payments are due on the first day of the month for that month’s coverage, you have a grace period of 30 days after the first day of the coverage period to make the payment. Your continuation coverage is provided for each coverage period as long as payment is made before the end of the grace period. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the plan. COBRA coverage cannot be reinstated if terminated due to a late payment.

As of this date, we have not received your COBRA premium payment for the month of [month]. If your grace period of 30 days expires, please accept this letter as notice that your COBRA continuation coverage will be terminated as of [last coverage date for last month for which payment was received].

If you have questions, please call me at [telephone number].

Sincerely yours,

[Name, Title]
[Complete Mailing Address]

Enclosures