DRAFT

Early Termination Notice

*[**Enter date of notice**] (must be sent as soon as practicable following determination that coverage shall terminate)*

Dear: *[**Identify the qualified beneficiary(ies), by name or status**]*

This notice is being sent to notify you that your continuation coverage [***has terminated*** or ***will terminate***] on [***date***] because:

[***event causing early termination***].

- ☐ You did not pay your premium timely
- ☐ You have obtained other health care coverage
- ☐ You have become entitled to Medicare benefits
- ☐ Your employer no longer offers group health insurance
- ☐ You fail to meet the plan's eligibility requirements
- ☐ Other: _____

Tufts Health Plan's Non-Group Plan may be available. Please contact a Tufts Health Plan member services representative at 1-800-462-0224 for information on Non-Group Plan coverage.

To be eligible for the non-group coverage described above, you must live within the Tufts Health Plan service area. However, if you no longer live within the Tufts Health Plan service area, we suggest you contact an insurance agent or broker or the Department of Insurance in the state in which you reside to determine what options are available to you. Please note: other plans may require you to enroll within 63 days of your loss of group coverage in order to avoid preexisting conditions exclusions.

If you have any questions about this notice or your rights to continuation coverage, you should contact [***enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address***].

Sincerely,