Partial Premium Payment Notification Letter

(if missing amount *is not* significant)

Note: Missing premium is < $50 or 10% of the total premium

**{Date of COBRA Letter}**

**To: {Name of COBRA Qualified Beneficiary EE}, {Name of COBRA Qualified Beneficiary Spouse}** and all covered dependents

**{Address of COBRA Qualified Beneficiary}**

# RE: Partial COBRA Premium Payment – 30 day payment notice

Under the terms and conditions of continuing your health insurance coverage under COBRA, you are required to pay your ***full*** monthly premium in the amount of *enter amount due* on the first of each month. If you fail to make the premium payment on that date, you have a maximum grace period of 30 days to pay, otherwise your coverage can be cancelled.

On *enter date*, we received your check number \_\_\_\_\_\_\_\_ in the amount of *enter amount* for the payment of your *enter month* COBRA premium. However, the ***full*** monthly premium you agreed to pay when you elected COBRA continuation coverage was *enter amount.* Therefore, your premium payment is short *enter amount of shortage* and you are in danger of losing your health insurance coverage unless the full premium is paid.

**30 day premium payment window**

Since the premium you paid is not significantly less than the full premium (defined as < $50 or 10% of the premium due), you are provided with a 30-day period from the date of this letter to pay the short amount. You must send this additional premium no later than *enter date*. Important Note: This 30-day premium payment window will overlap the due date of your next month’s COBRA premium. If a check is received for that month prior to the payment of this month’s short amount, that check will be held pending receipt of the short amount.

**Claim Payments:** While awaiting this premium, please be advised all payments for claims occurring in the month will not be paid. If your full premium is paid, these claims will immediately be released for payment according to the schedule of benefits. If a medical provider calls for verification of benefits, they will be advised that you are covered, but that you are subject to retroactive cancellation if the full premium is not paid.

# Cancellation of COBRA coverage if full payment is not made

If the short amount is not sent prior to *enter date*, then your COBRA coverage will be cancelled back to the end of the month in which a full premium was paid. The *enter amount paid* you have already paid will be refunded back to you and you will not be eligible for reinstatement. You will not receive any additional notices.

**Questions:**

Should you have any questions regarding this notice, please contact **{employer contact},** at **{employer contact phone number},** Human Resources **{Employer Name}, {Employer Address}**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***

Partial Premium Payment Notification Letter

(if missing amount *is* significant)

Note: Note: Missing premium is > $50 or 10% of the total premium

**{Date of COBRA Letter}**

**To : {Name of COBRA Qualified Beneficiary EE}, {Name of COBRA Qualified Beneficiary Spouse}** and all covered dependents

**{Address of COBRA Qualified Beneficiary}**

# RE: Partial COBRA Premium Payment

Under the terms and conditions of continuing your health insurance coverage under COBRA, you are required to pay your ***full*** monthly premium in the amount of *enter amount due* on the first of each month. If you fail to make the premium payment on that date, you have a maximum grace period of 30 days to pay, otherwise your coverage can be cancelled.

On *enter date*, we received your check number \_\_\_\_\_\_\_\_ in the amount of *enter amount* for the payment of your *enter month* COBRA premium. However, the ***full*** monthly premium you agreed to pay when you elected COBRA continuation coverage was *enter amount.* Therefore, your premium payment is short *enter amount of shortage* and you are in danger of losing your health insurance coverage unless the full premium is paid.

**Claim Payments:** While awaiting this premium, please be advised all payments for claims occurring in the month will not be paid. If your full premium is paid, these claims will immediately be released for payment according to the schedule of benefits. If a medical provider calls for verification of benefits, they will be advised that you are covered, but that you are subject to retroactive cancellation if the full premium is not paid.

# Cancellation of COBRA coverage if full payment is not made

If the short amount is not sent prior to *enter date*, then your COBRA coverage will be cancelled back to the end of the month in which a full premium was paid. The *enter amount paid* you have already paid will be refunded back to you and you will not be eligible for reinstatement. You will not receive any additional notices.

**Questions:**

Should you have any questions regarding this notice, please contact **{employer contact},** at **{employer contact phone number},** Human Resources **{Employer Name}, {Employer Address}**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***

## Insufficient Funds Notification

**{Date of COBRA Letter}**

**To : {Name of COBRA Qualified Beneficiary EE}, {Name of COBRA Qualified Beneficiary Spouse}** and all covered dependents

**{Address of COBRA Qualified Beneficiary}**

# RE: Return of insufficient funds check for your COBRA Premium Payment

On *enter date* we received your check number \_\_\_\_\_\_\_, in the amount of *enter amount* for the payment of you *enter month and year* COBRA premium. The check was submitted to the bank, however on *enter date*, your check was returned to us marked insufficient funds. We realize that errors and/or oversights can occur, so our procedure is to resubmit your check **once** for payment. So be advised that as of this date, you have not made a timely premium payment for your COBRA continuation coverage.

**Premium Grace Period:**

While your premium was due on the first of the month, COBRA law allows you a maximum (30) day grace period in which to pay your monthly premiums. This is the maximum grace period, as the plan does not provide any additional time beyond that. Therefore, to keep your COBRA group health insurance in force, your check must clear the bank within the specified period, which ends on (*enter date*). Please take the appropriate steps to ensure the needed funds are deposited in your account. Or, if you wish to make some other type of payment, cashier’s check or money order, please contact us immediately.

**Claim Payments:** While awaiting this premium, please be advised all payments for claims occurring in the month will not be paid. If your full premium is paid, these claims will immediately be released for payment according to the schedule of benefits. If a medical provider calls for verification of benefits, they will be advised that you are covered, but that you are subject to retroactive cancellation if the full premium is not paid.

# Cancellation of COBRA coverage if timely payment is not made

If proper and timely payment is not made prior to *enter date*, then your last day of COBRA coverage will be *enter date* and you will not be eligible for reinstatement. You will not receive any additional notices.

**Questions:**

Should you have any questions regarding this notice, please contact **{employer contact},** at **{employer contact phone number},** Human Resources **{Employer Name}, {Employer Address}**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***