

**NOTICE OF UNAVAILABILITY OF COBRA CONTINUATION COVERAGE
(Explanation)**

This is a letter that notifies a participant and/or beneficiary that has sent the Fund a Notice of Qualifying Event to obtain COBRA continuation coverage that he/she is not entitled to COBRA. The Notice must explain why COBRA is not available to the participant and/or beneficiary.

The Notice should be sent within the same timeframe as the Fund would send a COBRA Election notice to an eligible individual who had sent the Fund a Notice of Qualifying Event (which is 14 days).

The final COBRA rules require that this notice be sent: (a) when the Plan receives a Notice of Qualifying Event from a participant or beneficiary and the Plan determines that no qualifying event has occurred, or (b) when a qualified beneficiary did not furnish the Notice of Qualifying Event in a timely manner or did not provide complete information.

[FUND/PLAN LETTERHEAD]

[Notice of Unavailability of COBRA Continuation Coverage]

Date:

Dear _____:

Our records indicate that you provided the Connecticut Carpenters Health Fund (the "Plan") with a Notice of Qualifying Event seeking to obtain or extend COBRA coverage for yourself and/or your dependents due to one of the following qualifying events:

(Check one)

- (a) Your divorce or legal separation.
- (b) A child's loss of status as an Eligible Dependent.
- (c) You and/or your Eligible Dependent(s) who are currently receiving COBRA have a second qualifying event due to a Member's death, divorce or legal separation, or a child losing Eligible Dependent status.
- (d) You or your Eligible Dependent(s) have received a determination of disability from the Social Security Administration.

We have determined that you and/or your Eligible Dependent(s) are not entitled to COBRA continuation coverage for the following reason:

[Examples:

- *The reason you lost coverage _____ (describe reason), was not a qualifying event;*
- *Your separation was not court-ordered;*
- *Although your child is age 19, s/he is still covered by the plan since s/he is a full-time college student;*
- *You did not provide the Notice of Qualifying Event within the required timeframe]*

Your coverage under the Plan is/was terminated effective: _____ and cannot be extended after that date.

Claims incurred on or after this date will not be paid by the Plan. Any claims incurred prior to this date should be filed immediately for processing.

If you have any questions about this determination please contact me.

Deborah L. Palmieri
Health Fund Administrator