

Employer (group) Name and address
on
Company Letterhead

Date:

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117

RE Termination of Group Coverage
Date of Termination:

Our company has provided the individuals listed below with coverage through a group health insurance policy.

Name of individual/s

This policy provided minimum essential coverage consistent within the requirements of the Affordable Care Act. Our company has terminated the group insurance policy with the carrier effective xx/xx/xxxx. This action results in a loss of coverage for the named individuals as of the date of termination.

Sincerely

Xxx xxxxx,
Title (owner, president, etc)