[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Subject: Notice of Cancellation of Benefits

Dear [Employee Name],

This letter is to formally notify you that your [Type of Benefit, e.g., Medical/Dental/Life Insurance] coverage through [Company Name] will be cancelled effective [Cancellation Date].

This cancellation is due to [Reason for Cancellation, e.g., termination of employment, reduction in hours, or non-payment of premiums].

Please take note of the following important information regarding your coverage:

- **Last Day of Coverage:** [Date]
- **COBRA Eligibility:** [You are / You are not] eligible for COBRA continuation coverage. A separate packet with enrollment details will be sent to you by [Method/Date].
- **Claims:** Any claims for services rendered on or before [Date] must be submitted by [Deadline Date].

If you have questions regarding your plan or the transition of your benefits, please contact the Human Resources Department at [Phone Number] or via email at [Email Address].

Sincerely,

[Your Name]
[Your Title]
[Company Name]