[Company Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

Subject: Notice of Right to Continue Health Care Coverage

Dear [Employee Name],

This letter is to inform you that your group health insurance coverage under the [Company Name] health plan will terminate on [Date] due to [Reason for Coverage Loss, e.g., termination of employment].

Under federal/state law, you and your eligible dependents may have the right to continue your health care coverage for a limited period of time. This is commonly referred to as COBRA or State Continuation coverage.

Important Information:

- **Coverage Options:** You may elect to continue your current medical, dental, and vision benefits.
- **Monthly Cost:** The total monthly premium for continuation coverage is $[Amount]. This includes the full premium plus a [Percentage]% administrative fee.
- **Duration:** Coverage can generally be continued for up to [Number] months.
- **Election Deadline:** You must complete and return the enclosed election form by [Date] to avoid losing your right to continue coverage.

If you choose to elect continuation coverage, your coverage will be retroactive to [Date of Coverage Loss], provided you pay the required premiums.

Please review the enclosed documents carefully. If you have any questions regarding your rights or the election process, please contact the Benefits Department at [Phone Number] or [Email Address].

Sincerely,

[Name/Signature]
[Title]
[Company Name]

Enclosures: Election Form, Premium Schedule