[Company Name]
[Department/HR Office]
[Address]
[City, State, Zip Code]

[Date]

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

Subject: Continuation of Health Benefits During FMLA Leave

Dear [Employee Name],

This letter is to provide information regarding the continuation of your group health insurance benefits during your approved Family and Medical Leave Act (FMLA) leave, which began on [Leave Start Date] and is expected to end on [Leave End Date].

Under FMLA regulations, you are entitled to maintain your health insurance coverage under the same conditions as if you had continued to work. To keep your coverage active, you are responsible for paying your portion of the monthly premium in the amount of $[Amount].

Please follow the instructions below to ensure your benefits remain uninterrupted:

- **Payment Amount:** $[Amount] per [Pay Period/Month].
- **Due Date:** Payments are due by the [Day] of each month.
- **Payment Method:** Please make checks payable to [Company Name] and mail them to [Address/Department].

A grace period of 30 days will be provided for each payment. If payment is not received within 30 days of the due date, your health coverage may be terminated for the remainder of your leave, provided we notify you in writing 15 days before coverage ends.

If you choose not to return to work following your FMLA leave for reasons other than a serious health condition or circumstances beyond your control, the company may seek reimbursement for the employer's share of health insurance premiums paid on your behalf during your leave.

Please contact [HR Contact Name] at [Phone Number] or [Email Address] if you have any questions regarding your benefits or payment schedule.

Sincerely,

[Name]
[Title]
[Company Name]