[Date]

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

Subject: Notice of Right to Continue Health Care Coverage (COBRA)

Dear [Employee Name],

This letter is to inform you that due to your furlough effective [Furlough Start Date], your current group health insurance coverage through [Company Name] will end on [Last Date of Coverage].

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your covered dependents have the right to continue your health care coverage at your own expense. This notice contains important information about your right to continue your health care coverage, as well as other health coverage options that may be available to you.

Plan Information:

- **Qualifying Event:** Furlough / Reduction in Hours
- **COBRA Start Date:** [Date]
- **Coverage End Date:** [Date (usually 18 months from start)]

Monthly Premium Costs:

- Medical: $[Amount]
- Dental: $[Amount]
- Vision: $[Amount]

How to Enroll:

To elect COBRA coverage, you must complete the enclosed Election Form and return it to [Department/Name] no later than [Election Deadline Date - 60 days from notice]. If you do not submit a completed form by this date, your rights to continue your health insurance will end.

Payment Information:

Your first premium payment is due within 45 days of your election. Please make checks payable to [Company/Provider Name] and mail them to [Payment Address].

If you have any questions regarding this notice or your benefits, please contact [HR Contact Name] at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]
[Title]
[Company Name]

Enclosure: COBRA Election Form