

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

[Date]

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

Subject: Notice of Benefits Suspension and COBRA Election Rights

Dear [Employee Name],

As previously communicated, your furlough from [Company Name] began on [Furlough Start Date]. This letter serves as formal notification regarding the status of your employee benefits during this period.

1. Suspension of Active Benefits

Your active participation in the company-sponsored health, dental, and vision plans will terminate effective [Benefit Termination Date]. This suspension is a result of the reduction in your work hours due to the furlough.

2. COBRA Coverage Election

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your covered dependents have the right to continue your current healthcare coverage at your own expense.

- **Enrollment:** To continue coverage, you must complete the enclosed COBRA Election Form and return it by [Election Deadline Date].
- **Cost:** If you elect to continue coverage, you will be responsible for the full monthly premium plus a 2% administrative fee. The monthly cost for your current plan is \$[Amount].
- **Duration:** COBRA coverage is generally available for up to 18 months from the date of the qualifying event.

3. Other Benefits

[Insert information regarding Life Insurance, 401(k), or Disability coverage here, e.g., "Your Life Insurance coverage will also cease on [Date], but you may be eligible for a policy conversion."]

4. Next Steps

Please review the attached COBRA Election Notice and Enrollment Form carefully. If you choose to elect coverage, please return the forms to [Department/Contact Name] at [Email/Address].

If you have questions regarding your benefits or the COBRA process, please contact the Human Resources Department at [Phone Number] or [Email Address].

Sincerely,

[Name]

[Title]

[Company Name]

Enclosure: COBRA Election Notice and Enrollment Form