

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

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

Subject: Information Regarding Continuation of Health Benefits

Dear [Employee Name],

This letter is to provide you with important information regarding your employee benefits following your [separation of employment / leave of absence], effective [Last Date of Employment/Coverage].

Health Insurance Continuation (COBRA)

You are eligible to continue your current health, dental, and vision insurance coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You will receive a formal COBRA election packet via mail from our plan administrator, [Name of Administrator], within [Number] days. This packet will include detailed instructions on monthly premiums and how to enroll.

Life Insurance and Disability

Your coverage under the company-sponsored life insurance and disability plans will end on [Date]. You may have the option to convert these policies to individual plans. To do so, you must contact the provider, [Provider Name], at [Phone Number] within [Number] days of your coverage end date.

Retirement Savings (401k)

Regarding your [401k/Retirement Plan], you will receive a separate notification from [Financial Institution Name] regarding your options for account distribution or rollover. If you have any immediate questions, you can reach them at [Phone Number].

Flexible Spending Accounts (FSA/HSA)

[Insert details regarding final claim submission dates or account portability].

Please ensure your contact information remains up to date in our records so that you receive all necessary tax documents and benefit notices. If you have any questions regarding this information, please contact the Human Resources Department at [Phone Number] or [Email Address].

Sincerely,

[Name]

[Title]

[Company Name]