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

[Date]

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

Subject: Notice of Right to Continue Medical, Dental, and Vision Coverage (COBRA)

Dear [Employee Name],

This letter contains important information about your right to continue your health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Your current coverage under [Company Name]'s group health plan will end on [End Date] due to [Reason for Termination/Reduction in Hours].

Your Right to Continued Coverage
You and your covered dependents (if any) have the right to choose to continue the health insurance coverage you currently have. This continuation of coverage is known as "COBRA coverage."

Duration of Coverage
If elected, your COBRA coverage will begin on [Start Date] and can last for up to [Number, e.g., 18] months.

Cost of Coverage
To continue your benefits, you must pay the full premium plus a 2% administrative fee. The monthly costs are as follows:

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

Election Period
To elect COBRA coverage, you must complete and return the enclosed Election Form by [Deadline Date]. If you do not submit the form by this date, your right to continue your benefits will expire.

Payment Information
Your first premium payment is due within 45 days of your election. Subsequent payments are due on the [Day] of each month. Please send payments to: [Payment Address/Instructions].

If you have any questions regarding this notice or your rights, please contact [Contact Person/Department] at [Phone Number] or [Email Address].

Sincerely,

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