

[Date]

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

**Subject: Notice of Right to Elect COBRA Continuation Coverage**

Dear [Employee Name],

This letter contains important information about your right to continue your health care coverage. Your group health insurance coverage under [Company Name] is scheduled to end on [Date] due to [Reason for Coverage Loss, e.g., termination of employment].

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and any covered dependents have the right to choose continuation coverage if your group health insurance is lost. Your continuation coverage period will last for up to [Number of Months] months.

**Plan Details:**

- **Monthly Premium:** \$[Amount]
- **Election Deadline:** [Date]
- **First Payment Due:** [Date]

To elect COBRA coverage, please complete the enclosed Election Form and return it to [Department/Name] by the deadline listed above. If you do not elect coverage by this date, your right to continue your health insurance will expire.

If you have questions regarding your rights or the cost of coverage, please contact [Contact Person/Department] at [Phone Number] or [Email Address].

Sincerely,

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