[Date]

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

Subject: Retirement Transition - Benefit Coverage Adjustment Questionnaire

Dear [Employee Name],

Congratulations on your upcoming retirement. To ensure a smooth transition of your health and welfare benefits, please complete this questionnaire regarding your coverage adjustments.

1. Retirement Date:
[_____]

2. Health Insurance Election:
Transition to Retiree Medical Plan (if eligible)
Transition to COBRA Continuation Coverage
Enrollment in Medicare (Part A/B/D)
Declining coverage (coverage through spouse or other source)

3. Dependent Coverage:
Will you be maintaining coverage for any eligible dependents?
Yes
No

4. Life Insurance Conversion:
Do you wish to convert your group life insurance to an individual policy?
Yes
No

5. Contact Information for Post-Retirement:
Personal Email: [_____]
Phone Number: [_____]

Please return this form to the Human Resources Department by [Deadline Date]. Failure to return this questionnaire may result in the automatic termination of benefits on your final day of employment.

If you have questions regarding your pension or 401(k) distributions, please contact the Benefits Office at [Phone Number].

Sincerely,

[Sender Name]
[Title]
[Company Name]