

[Date]

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

Subject: Important Notice Regarding Your Health Insurance Coverage

Dear [Recipient Name],

This letter is to inform you that your health insurance coverage under [Name of Plan/Policy] will end on **[Coverage End Date]**. After this date, you will no longer have insurance benefits through this plan.

Reason for Loss of Coverage:

[Insert reason, e.g., Termination of employment, Reduction in hours, End of eligibility period, or Plan discontinuation.]

What You Need to Know:

- **Final Day of Coverage:** Your benefits will remain active until midnight on [Date].
- **Claims:** Any medical services received after the date mentioned above will not be covered by this plan.
- **Prescriptions:** Ensure you fill any necessary prescriptions before your coverage expires.

Options for Future Coverage:

You may be eligible to continue your coverage or enroll in a new plan through the following options:

- **COBRA:** You may be eligible to continue your current group health insurance for a limited time. You will receive a separate COBRA enrollment election packet via mail.
- **Health Insurance Marketplace:** Loss of coverage is a Qualifying Life Event, allowing you to enroll in a plan through the Health Insurance Marketplace during a Special Enrollment Period.
- **Other Plans:** You may also be eligible for coverage through a spouse's employer plan or government programs like Medicaid.

If you have questions regarding this notice or your benefits, please contact the Benefits Department at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]
[Title]
[Company Name]