

**Date:** [Date]

**Subject:** NOTICE OF NON-RENEWAL OF HEALTH INSURANCE COVERAGE FOR DEPENDENT(S)

Dear [Employee Name],

This letter is to formally notify you that health insurance coverage for the dependent(s) listed below will not be renewed and will terminate effective [**Termination Date**].

**Affected Dependent(s):**

- [Dependent Name 1]
- [Dependent Name 2]

**Reason for Non-Renewal:**

Despite previous requests dated [Date of First Request] and [Date of Second Request], we have not received the required Dependent Eligibility Verification documents. To maintain coverage under our group health plan, all enrolled dependents must be verified through valid documentation (such as birth certificates, marriage licenses, or tax returns) to ensure they meet the plan's eligibility requirements.

**Impact on Coverage:**

Coverage for the individual(s) named above will cease at midnight on [Termination Date]. Please note that your own individual employee coverage is not affected by this specific notice and will continue as long as you remain eligible.

**How to Reinstating Coverage:**

If you have the required documentation, you must submit it to the Human Resources Department no later than [Final Deadline Date] to avoid a lapse in coverage. If documents are received after the termination date, your dependents may not be eligible for re-enrollment until the next Annual Open Enrollment period, unless you experience a qualifying life event.

If you believe this notice has been sent in error or if you have already submitted these documents, please contact the Benefits Department immediately at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]

[Title]

[Company Name]