

[Date]

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

Subject: Notification of Benefit Coverage Change - Dependent Age Limit Reach

Dear [Employee Name],

We are writing to inform you of an upcoming change to your health insurance coverage regarding your dependent, [Dependent Name].

According to our records, [Dependent Name] will reach the maximum age limit of [Age, e.g., 26] for coverage under your employer-sponsored plan on [Date]. Consequently, their coverage under your current policy will terminate effective [Termination Date].

What this means for you:

- Your dependent will no longer be eligible for medical, dental, or vision benefits through your plan after the date mentioned above.
- Your payroll deductions for insurance premiums may be adjusted to reflect this change in coverage level.

Options for continued coverage:

The loss of coverage due to "aging out" is considered a Qualifying Life Event. Your dependent may be eligible for:

- COBRA continuation coverage (separate documentation will be mailed regarding this option).
- Enrollment in a plan through the Health Insurance Marketplace.
- Enrollment in their own employer-sponsored plan, if applicable.

If you believe this information is incorrect or if your dependent qualifies for an extension due to a disability, please contact the Human Resources Department immediately at [Phone Number] or [Email Address].

Sincerely,

[Your Name/Department]
[Company Name]