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

[Date]

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

Re: Termination of Employment and Cancellation of Insurance Benefits

Dear [Employee Name],

This letter is to formally notify you that your employment with [Company Name] is terminated, effective [Effective Date].

As a result of your termination, your participation in the company-sponsored insurance plans will end as follows:

- **Health, Dental, and Vision Insurance:** Your coverage will remain active until [Coverage End Date].
- **Life and Disability Insurance:** Your coverage will expire on [Coverage End Date].

Following the termination of your group health coverage, you may be eligible to continue your insurance under COBRA. You will receive a separate enrollment package via mail containing detailed information on premium costs and election deadlines.

If you have any questions regarding your final paycheck, unused vacation time, or benefit conversion options, please contact the Human Resources Department at [Phone Number] or [Email Address].

We thank you for your service to [Company Name] and wish you the best in your future endeavors.

Sincerely,

[Signature]
[Name of Sender]
[Title]