[Company Letterhead]

[Date]

[Insurance Provider Name]
[Insurance Provider Address]
[City, State, Zip Code]

Subject: Verification of Termination of Health Benefit Coverage

To Whom It May Concern,

This letter is to formally verify that [Employee Full Name] is/was employed at [Company Name].

Due to [Reason: e.g., termination of employment, reduction in hours, or plan cancellation], the individual named above has experienced a loss of health insurance benefits.

Please find the coverage termination details below:

- **Employee Name:** [Employee Full Name]
- **Employee ID/SSN (Last 4 digits):** [XXXX]
- **Last Date of Employment:** [Date]
- **Benefit Coverage End Date:** [Date]
- **Types of Coverage Lost:** [e.g., Medical, Dental, Vision]
- **Dependent Coverage:** [Names of covered dependents, if applicable]

This loss of coverage constitutes a Qualifying Life Event (QLE) for the purpose of enrolling in a new insurance plan.

If you require any further information or additional documentation, please contact the Human Resources Department at [Phone Number] or [Email Address].

Sincerely,

[Signature]

[Printed Name]
[Job Title]
[Company Name]