COBRA

Consolidated Omnibus Budget Reconciliation Act

Sample Letter for Terminated Employees

[Date]

EMPLOYEE
ADDRESS

Dear_______:

In accordance with Federal law, you are eligible to continue your health plan under which you and your dependents are currently covered for a period of up to 18 months. The continuation can be extended to 36 months in certain events (Death of the employee, Medicare entitlement, Divorce or legal separation, Child no longer eligible, Chapter 11 bankruptcy).

Your current medical rate is $_________. Each payment is due to the employer the ______ of the month. If we do not receive payment on time, your COBRA coverage will end due to non-payment. If the Company's group rating increases at the renewal date, you will be notified and your premium will be adjusted accordingly. The premium is due before the first of each month for coverage to be continued. Please notify me within 60 days from the date of this letter if you intend to elect COBRA continuation.

If you have any questions, please do not hesitate to contact me immediately.

Sincerely,

____

Please check one block and sign

☐ I have been covered under the group health insurance program for the past three months. My employment is ending and I want to continue my group coverage for up to eighteen additional months by paying the entire fee to you, monthly, in advance.

My last day of employment is ____

________________________________ ____________________
Employee's Signature Date Signed

☐ I do not want to continue my group coverage

________________________________ ____________________
Employee's Signature Date Signed