

**PLEASE RE-TYPE
ON YOUR
COMPANY LETTERHEAD**

DATE

Employee Name
Address
City, State & Zip Code

Dear Sir or Madam,

As of the date of termination, which is 00/00/00 you are entitled to elect NY State Continuation / COBRA, for 18 months (through voluntary or involuntary dismissal) under our group major medical plan. Should you desire this coverage, please complete the enclosed form and mail back with the monthly premium for MEDICAL COMPANY in the amount of: \$_____.

Your premium will be due on the 25th of the month and must reach us before that date, in order to avoid termination. Please make check payable to CLIENT via certified mail return receipt.

You must notify us no later than 60 days from the date of this letter that you are making this election.

Thank you for your consideration and your prompt attention to this matter.

Sincerely,

X
OWNER
