

Less than 20 employees: Cal Cobra

CO LETTERHEAD

Date:

Insurance Co name: _____

Group Name: _____

Group Number: _____

This serves as notification that the following employee is no longer employed by our company.

Please note the following information.

Employee Name: _____

Last date of employment: _____

Social Security Number: _____ - _____ - _____

Most current employee address: _____

Please send this employee all necessary CAL COBRA documents

If you have any questions regarding the above request please call us at _____

Sincerely,

Benefits Administrator