

Notice of Termination of Comprehensive Coverage Benefits

Date: [Insert Date]

[Recipient's Name]

[Recipient's Address]

[City, State, Zip Code]

Dear [Recipient's Name],

We regret to inform you that your comprehensive coverage benefits with [Company Name] will be terminated effective [Termination Date]. This decision has been made due to [brief reason for termination, e.g., non-payment, policy expiration, etc.].

Please note that this termination will result in the cancellation of all coverage provided under your current benefits plan, including [list specific coverages affected]. We encourage you to review any remaining health options you may have.

If you believe this termination is in error or if you have questions about this decision, please do not hesitate to contact us at [Customer Service Phone Number] or [Customer Service Email]. We are here to assist you during this transition.

Thank you for your understanding.

Sincerely,

[Your Name]

[Your Title]

[Company Name]

[Company Address]

[City, State, Zip Code]