

# Coverage Continuation Options

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

Dear [Recipient's Name],

We are writing to inform you about your options for continuing your health coverage after [specific event, e.g., job termination, reduction in hours, etc.]. It is important to understand your rights and the options available to ensure you maintain essential health benefits.

## Coverage Continuation Options

You may be eligible for the following coverage options:

- **COBRA Coverage:** If you have experienced a qualifying event, you may continue your group health plan coverage under COBRA for up to 18 months.
- **Marketplace Options:** You may explore health insurance plans available through the Health Insurance Marketplace.
- **Medicaid:** Depending on your income, you may qualify for Medicaid coverage. Please check your eligibility.
- **Short-Term Insurance:** Consider purchasing short-term health insurance for temporary coverage.

If you have any questions regarding these options or would like assistance in selecting the best choice for your situation, please feel free to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this important matter. We are here to support you in ensuring continued health coverage.

Sincerely,

[Your Name]

[Your Title]

[Your Company/Organization]