

**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