

SEND CERTIFIED MAIL

LWOP CANCELLATION OF COVERAGE (Sample Letter)

FINAL NOTICE

(Date)

(Name, Inside Address)

Dear (Employee Name):

Upon receiving a Personnel Action Form placing you on Leave Without Pay (LWOP) status beginning _____(date), this office sent you two prior notices providing you with premiums amounts and their due date in order to keep your benefits coverage in effect.

To date we have not received a response from you, therefore this letter is to advise you that your benefits coverage(s) will be cancelled if payment is not received in this office on or before _____(2 weeks from date of this notice).

If benefits are cancelled due to non-payment, please be advised that your benefits will be made to end on the last day of the pay period in which the last premium payment was made. Any claims incurred after that time will be your full responsibility.

We regret this action has become necessary however, in order to avoid loss of benefit(s) coverage, all benefit premiums due must be submitted to this office on or before the due date stated above, no exceptions.

Upon return to work and have been on LWOP (instead of unpaid FML), you will have to wait until the next Open/Switch Enrollment Period, or a have experienced a valid Qualifying Event in order to start your benefit coverage(s) again.

Sincerely,

(HR Rep)
Title