SEND CERTIFIED MAIL

FMLA CANCELATION OF COVERAGE (Sample Letter)

FINAL NOTICE

(Date)

(Inside Address)

Dear (Employee Name):

Upon receiving a Personnel Action Form placing you on Family Medical Leave (FMLA) status beginning ________(date), this office sent you two notices providing you with the dates and amounts of premiums due in order to keep your benefits coverage in effect. FMLA guidelines allow an employee a 30-day grace period to submit benefit premiums, however as of today, we have not received any response or premium payment from you.

Therefore, this letter is to advise you that your benefits coverage(s) will be canceled if payment is not received in this office on or before _____________(30 days from date of this notice).

If benefits are canceled due to non-payment, please be advised that the last day of your benefit coverage(s) will be 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, benefits can be reinstated if you have been on FMLA. If you have been on LWOP (not unpaid FMLA), 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,

Name
Title