{Date}

State of New York
Department of Civil Service
Employee Benefits Division
The W. Averell Harriman
State Office Building Campus - Building 1
Albany, NY 12239

 RE: COBRA Coverage for dependent of {Employee’s Name}

 Dear COBRA Unit:

I am writing to request a COBRA application for my dependent who recently lost health insurance coverage due to a change in status.

My name:
The last 4 digits of my Social Security Number:
My dependent’s name:
My dependent’s last day of coverage was:

Please send the application to my home address:

{Address}
{Address 2}
{City, State, Zip}

Thank you for your attention to this. If you have any questions, please feel free to call me daytime at {xxx-xxx-xxxx}.

Sincerely,

{Your Name}