{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}