{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 name}
SS#: {SS#}

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 is {Name}, my social security number is {SS#}, and my dependent {Name} has lost coverage as of {last day covered}.

Please send the application to my home address listed below:

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

Thank you for your attention to this matter. If you have any questions, please feel free to give me a call at {telephone number}.

Sincerely,

{Name}