BENEFITS CONTINUATION LETTER

[Date]
[Employee Name]
[Street Address]
[City, State Zip]

RE: BENEFITS CONTINUATION

Dear *[Employee Name]*:

As previously discussed, the *[Parish/School/Diocese]* has approved your request for a [Medical / Family or Pregnancy Disability] leave of absence. For the duration of this leave, the *[Parish/School/Diocese]* will continue to make the same premium contribution as if you had continued working, but you must continue to make the same monthly benefit premium payments during the leave as before the leave started. Below we have detailed the employee's portion of your current insurance plans:

	Pay Period Cost	**Monthly Cost**
Medical Insurance	$	$
Dental Insurance	$	$
Vision Insurance	$	$
Life Insurance	$	$
Other: [list]	$	$
Total:	$	$

Please note if you exhaust all available sick or vacation pay, your benefits payment should be mailed to:

[Name]
[Street Address]
[City, State Zip]

If you have any questions or concerns, please contact *[Name]* at *[contact information]*.

Sincerely,