[Date]

[Eligible Provider Name]
[Address]
[City], [State] [Zip]

Health Care Fund ID: [U Number]

RE: [Ongoing Eligibility Status: New Plan Year, Proof of Coverage Needed]

Dear [Provider Name]:

Thank you for participating in the Child Care Providers United (CCPU) Health Care Reimbursement Fund. We need to confirm your medical insurance coverage beginning January 2025. This confirmation will allow you to continue to access the CCPU Health Care Fund benefits and MetLife dental and vision benefits for the 2025 plan year.

To continue your benefits, we need the following information:

___X___Proof of Coverage of your current medical insurance plan: This supplementary documentation should provide details that verify your name as the policyholder, your health care plan name, and the coverage period, and updated monthly premium.

For information on acceptable documentation guidelines, please visit our website Resources page via the following QR Code:

We kindly request that you provide us with the additional information by **December 20th** to avoid any potential interruption in your benefits. If you do not submit proof of coverage, your Healthcare Reimbursement benefits and MetLife dental and vision benefits will end 12/31/2024. You can submit your information to:

Mail: CCPU Health Care Fund
P.O. Box 57027
Irvine, CA 92619

Email: eligibility@ccpuhealth.org

Fax: (949) 809-8943

Please be sure to include your CCPU Health Care Fund ID [U Number] on all correspondence you send.

If you have any questions, please contact us at (833) 714-6028.

Thank you,

CCPU Health Care Fund