[DATE]

Contact Name

Address

Address2

City,

State/Province

Zip/Postal Code

**RE: REQUEST FOR IMMEDIATE MEDICAL AID COVERAGE ON NEW EMPLOYEE [FULL NAME]**

Dear [CONTACT NAME],

Please find enclosed an enrolment form for the above-captioned individual. [EMPLOYEE] is a transfer from [SPECIFY]. It is the [NAME OF COMPANY] desire to waive the waiting period. We are requesting immediate coverage on this employee.

Your consideration in this matter will be appreciated.

Kind Regards,

[YOUR NAME]

[YOUR TITLE]

[YOUR PHONE NUMBER]

[YOUREMAIL@YOURCOMPANY.COM]