Prior Carrier Cancellation

Date: _____

TO: _____
(Insurance Carrier)

FR: _____
(Company Name)

_____
(Group Policy Number)

RE: Termination of group insurance

To Whom It May Concern:

Please cancel our group _____ coverage,
(Medical)

Effective _____/_____/_____

Sincerely,

_____
Signature Date

_____
Print Name Title

License # 0B42994 – CaliforniaChoice Benefit Administrators, Inc.
License # 0N14196 – ChoiceBuilder Insurance Services

CHOICE Administrators®