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®