[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email]

[Date]

[Old Health Insurance Company Name]
[Department Name, if applicable]
[Address]
[City, State, Zip Code]

RE: Notice of Cancellation of Health Insurance Policy

To Whom It May Concern,

Please accept this letter as formal notification to cancel my health insurance policy with [Old Health Insurance Company Name].

Policy Details:
Policyholder Name: [Your Full Name]
Policy Number: [Your Policy Number]
Group Number: [Your Group Number, if applicable]

I am switching my coverage to a new provider. Please terminate my coverage effective [End Date of Coverage]. I understand that any services rendered after this date will not be covered under this policy.

Please provide written confirmation of this cancellation and the final date of coverage for my records. If I am entitled to any refund for prepaid premiums, please issue the payment to my address on file within [Number] days.

If there are any further steps or forms required to finalize this cancellation, please contact me immediately.

Sincerely,

[Signature]
[Your Printed Name]