[Current Date]

[Member Name]
[Member Address]
[City, State, Zip Code]
[Phone Number]

[Insurance Company Name]
[Department Name]
[Company Address]
[City, State, Zip Code]

Subject: Confirmation of Health Insurance Cancellation

Policy Number: [Insert Policy Number]
Group Number: [Insert Group Number]
Requested Cancellation Date: [Insert Date]

To Whom It May Concern,

I am writing to formally confirm my request to cancel my health insurance policy effective as of the date listed above. I understand that coverage for myself and any dependents listed under this policy will terminate on this date.

Please process this cancellation and stop all future premium withdrawals. I request a written confirmation of this cancellation for my records.

By signing below, I acknowledge that I am voluntarily terminating this coverage and understand the implications of being without health insurance.

Sincerely,

_____
[Member Signature]

[Member Printed Name]

Date signed: _____