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

[Date]

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

RE: Voluntary Cancellation of Workers' Compensation Policy

Policy Number: [Your Policy Number]
Effective Date of Cancellation: [MM/DD/YYYY]

To Whom It May Concern,

Please accept this letter as formal notification to cancel the above-mentioned Workers' Compensation policy. I am requesting a voluntary cancellation effective [MM/DD/YYYY].

The reason for this cancellation is [Reason: e.g., switching to a new provider, business closure, or no longer having employees].

Please stop all automatic payments and premium withdrawals associated with this policy as of the cancellation date. I request a written confirmation of this cancellation and a statement of any outstanding balance or unearned premium refund due to me.

Please mail the confirmation and any applicable refund checks to the address listed above.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Title/Position]