

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

[Date]

[Insurance Carrier Name]
[Carrier Address]
[City, State, Zip Code]

RE: Request for Policy Cancellation

Policyholder: [Insured Business Name]
Policy Number: [Policy Number]
Effective Date of Cancellation: [MM/DD/YYYY]

To Whom It May Concern,

Please accept this letter as a formal request to cancel the above-referenced Workers Compensation policy effective [Time, e.g., 12:01 AM] on [Date].

The reason for this cancellation is: [Reason, e.g., Insured has moved coverage to a new carrier / Business has ceased operations / Business has been sold].

Please process this cancellation and provide a final audit of the policy as required. Any unearned premiums should be returned to [the Insured / the Agency] at the address listed above.

We have attached the Lost Policy Release (LPR) form signed by the insured for your records.

Please confirm receipt of this request and provide a notice of cancellation once processed.

Sincerely,

[Agent Name]
[Title]
[Agency Name]