[Company Name]
[Address Line 1]
[City, State, Zip Code]
[Date]

[Contact Name]
[Client Company Name]
[Client Address Line 1]
[City, State, Zip Code]

Subject: Confirmation of Group Health Insurance Policy Cancellation

Dear [Contact Name],

This letter serves as formal confirmation that your group health insurance policy, number [Policy Number], has been cancelled per your request dated [Date of Request].

The cancellation is effective as of [Effective Date of Cancellation]. Coverage for all enrolled employees and dependents under this policy will cease at 11:59 PM on this date.

Important Information Regarding the Cancellation:

- **Final Premium:** Any outstanding premiums due up to the cancellation date must be paid in full. If your account has a credit balance, a refund will be issued within [Number] business days.
- **Employee Notification:** As the employer, you are responsible for notifying your employees regarding the termination of their coverage and providing any legally required notices concerning COBRA or state continuation rights.
- **Claims Processing:** Any medical claims incurred prior to the effective cancellation date will continue to be processed according to the terms of the policy.

If you have questions regarding this cancellation or if you require assistance with a new policy in the future, please contact your account manager at [Phone Number] or [Email Address].

Sincerely,

[Your Name/Department]
[Insurance Provider Name]