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

[Date]

[Policyholder Name]
[Policyholder Address]
[City, State, Zip Code]

**Subject: Confirmation of Medicare Supplement Policy Cancellation**

Dear [Policyholder Name],

This letter is to formally confirm that we have processed the request to cancel your Medicare Supplement (Medigap) insurance policy. Below are the details regarding this cancellation:

- **Policy Number:** [Policy Number]
- **Plan Type:** [Plan Letter, e.g., Plan G]
- **Cancellation Effective Date:** [Effective Date]

Your coverage under this policy will officially end at 11:59 PM on the cancellation effective date listed above. After this time, this policy will no longer pay for healthcare costs not covered by Original Medicare.

**Premium Information:**
[Option A: No further premiums are due for this policy.]
[Option B: Any unearned premium paid beyond the cancellation date will be refunded to you via [Check/Direct Deposit] within [Number] business days.]

If you have questions regarding this cancellation or if you believe this has been processed in error, please contact our Customer Service Department at [Phone Number] between the hours of [Hours of Operation].

Thank you for the opportunity to have served your healthcare insurance needs.

Sincerely,

[Name/Signature]
[Title]
[Company Name]