[Company Name/Insurance Provider Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Policyholder Name]
[Address Line 1]
[City, State, Zip Code]

Subject: Confirmation of Dependent Coverage Cancellation

Dear [Policyholder Name],

This letter is to confirm that the health insurance coverage for the dependent(s) listed below has been cancelled as requested.

Policy Number: [Policy Number]
Cancellation Effective Date: [Effective Date of Termination]

Removed Dependent(s):

- [Dependent Name 1]
- [Dependent Name 2]

Please note that coverage for the above-named individual(s) ended at 11:59 PM on [Effective Date of Termination]. Any claims incurred after this date will not be eligible for reimbursement under this policy.

If your premium is paid through payroll deduction, your contribution amount will be adjusted starting with the [Date] pay period. If you pay directly, a revised invoice or refund for any overpayment will be sent to you shortly.

If you believe this cancellation was processed in error, or if you have any questions regarding this change, please contact our Member Services department at [Phone Number] or via email at [Email Address].

Sincerely,

[Name of Sender/Department]
[Title]
[Company Name]