Click to Add a Date

Click to Add Company Name

Click to Add Street Address

Click to Add City, State, Zip

**RE:** **Click to Select Carrier** **Group Coverage Termination**

To Whom It May Concern:

Please accept this letter as formal notification to terminate the group coverage(s) marked below. The group number and requested termination effective date for each group plan is also included in the table below.

|  |  |  |
| --- | --- | --- |
| **group coverage**  | **policy number** | **requested termination date** |
|[ ]  Medical | Click to Add Policy Number | Click to Add MM/DD/YYYY |
|[ ]  Dental | Click to Add Policy Number | Click to Add MM/DD/YYYY |
|[ ]  Vision | Click to Add Policy Number | Click to Add MM/DD/YYYY |
|[ ]  Life | Click to Add Policy Number | Click to Add MM/DD/YYYY |
|[ ]  AD&D | Click to Add Policy Number | Click to Add MM/DD/YYYY |
|[ ]  STD | Click to Add Policy Number | Click to Add MM/DD/YYYY |
|[ ]  LTD | Click to Add Policy Number | Click to Add MM/DD/YYYY |

Please do not hesitate to contact me with any questions.

Sincerely,

 Click to Add Signature Date

Type Name Click to Add Title