

**Date:** \_\_\_\_\_

**TO:** \_\_\_\_\_  
(Insurance Carrier)

**FR:** \_\_\_\_\_  
(Company Name)

\_\_\_\_\_  
(Group Policy Number)

**RE:** Termination of group insurance

To Whom It May Concern:

Please cancel our group medical coverage, effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_

We have been approved for health coverage through Kaiser Permanente  
Choice Solution effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sincerely,

\_\_\_\_\_  
**Signature** **Date**

\_\_\_\_\_  
**Print Name** **Title**