

**Name**  
**Address**  
**Line2**  
**City, State Zip**

**Date**

Horizon BCBS of NJ  
**Attn: Member Services/ Termination**  
PO Box 1177  
Newark, NJ 07105

FAX: (973) 274-4485

RE: Termination of Policy # \_\_\_\_\_

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To Whom It May Concern:

Please be advised that I wish to **terminate** my insurance coverage as of **Date** as my new Medicare coverage will become effective as of **Date**.

Please cease and desist any further bank drafts from my account effective **Date**.

Please return any unused premium.

Thank you for your attention to this matter.

Sincerely,

**Name**