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 **# _____**

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