Name
Address
City, State Zip

Date

Horizon BCBS Of Nebraska

Attn: Member Services/ Termination

FAX: (402) 548-4685

RE: Termination of ID #

To Whom It May Concern:

*Please be advised that I wish to terminate my Medicare supplement insurance coverage as of **Date**. I have obtained new Medicare supplement Coverage that has become effective as of **Date**.*

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

Thank you for your attention to this matter.

Sincerely,