Name
Address
Line 2
City, State Zip

Date

Humana, Inc.
Attn: Medicare Supplement Disenrollment

PO Box 14601
Lexington, KY 40512-4601

FAX: 1-800-633-8188

RE**: Number: _____ Plan _____**

To Whom It May Concern:

Please be advised that I wish to terminate my Medicare Supplement coverage effective **Date**, as my new coverage will begin on **Date**. I have taken the same plan at a lower monthly premium

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

Please return any unused premium.

Should you have any questions, please do not hesitate to contact me at **Number.**

Thank you,

Name