Name
Address
Line2
City, State Zip

GPM Life Insurance Companay
Policy Holder Services

Fax: 402-997-1906

RE: *Termination of Policy _____ Plan ___*

To Whom It May Concern:

Please be advised that I wish to terminate my Medicare Supplement coverage as of ***Date****. I have obtained coverage elsewhere starting* ***Date****.*

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

Thank you for your attention to this matter.

Sincerely,

Name