

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

**GPM Life Insurance Company**  
**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**