

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