



CANCELLATION REQUEST

To: Assurant Health
Attn: Enrollment
Via Facsimile
1 (866) 387-3406

From: _____

Date: _____

Re: Policy No: _____

To Whom It May Concern:

Please cancel the above referenced policy/policies effective _____.
(DATE)

If you have any questions, please contact me at the address listed above or call me at:

_____.

Signed,

(SIGNATURE)

(NAME PRINTED)