Florida's Choice HEALTH CARE

RE: Cancellation of Current Health Care Provider/Return to Medicare as primary

Date: _____

Cancellation of _____

Policy # _____ Plan #_____

Patients name, _____Date of birth, _____ Medicare #. _____

To Whom it may concern:

I am sending you this written notice to request cancellation of my insurance effective _____

I wish to have Medicare return as my primary insurer to better assist my current health needs.

Under Medicare guidelines I expect you to respect my CHOICE in who provides my health care coverage and request this change effective immediately

In addition, I would appreciate you sending me written confirmation that the cancellation has been put into effect.

Thank you for your attention to this matter.

Sincerely,

X _____ X _____
Print Sign

X_____ X _____
Witness Print Sign

Name: _____
Adress: _____
City and Zip code:
Contact: _____