



CANCELLATION REQUEST

To: Select Health
Attn: Enrollement
Via Facsimile
(801) 442-3342

From: _____

Date: _____

Re: Policy No: _____

To Whom It May Concern:

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

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

_____.

Signed,

(SIGNATURE)

(NAME PRINTED)