DATE:

**INSERT INSURANCE COMPANY**

**NAME AND ADDRESS**

**HERE**

Attn: Account Manager

Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Current Insurance Carrier:

Please cancel the Community Rated plan listed below with associated group number, effective December 31, 2021. Thank you for your service, we are moving to the Greater Tompkins County Municipal Health Insurance Consortium effective January 1, 2023.

Please terminate the Broker Agency **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** associated with the group name and group number listed below, effective December 31, 2022.

*Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Current Group Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sincerely,

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CC: Broker Agency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**