

Cancellation Request for Symetra Insurance

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

Empower<sup>3</sup> Center For Health  
501 Howard Avenue, Ste. B204  
Altoona, PA 16601

Email       jframe@empower3cfh.com  
FAX         877-227-1753

I, \_\_\_\_\_ (patient name),  
would like to terminate my health insurance coverage through Symetra Life  
Insurance Co. effective \_\_\_\_\_ (date).

Sincerely,

\_\_\_\_\_ Patient Signature

\_\_\_\_\_ Patient Name (printed)

\_\_\_\_\_ Patient Address

\_\_\_\_\_ Patient City, State, ZIP

NOTE: Cancellations must be received by the 9<sup>th</sup> of the month by 4:00 pm in order to be processed for the 1<sup>st</sup> of the following month. If termination request is received on the 10<sup>th</sup> or after, your termination date will be in two month.

*(i.e If your termination is received January 9, your policy will be canceled February 1. If your termination is received January 10, your policy will be canceled March 1.)*

Reason for termination: \_\_\_\_\_