

# Health Policy Cancellation

Please check the box next to your insurance company's name.

ManhattanLife Assurance  Manhattan Life  Family Life

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I request cancellation of Policy Number \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(date) (month) (year)

Policyholder's Printed Name \_\_\_\_\_

Policyholder's Signature \_\_\_\_\_

Telephone Number \_\_\_\_\_

**Submit Completed Form to:**  
Policy Holder Services  
P.O. Box 925989  
Houston, TX 77292