Cancellation Form

INF Health Care – Cancellation of Coverage Form

Please complete this form ONLY if you are requesting Cancellation of Coverage before the start date of insurance. There are **no** exceptions to this policy. You may fax the completed forms to 408-520-4967. Incomplete forms or forms without authorized signature will not be processed. Also note that you cannot cancel policy for one policy holder if there are multiple persons listed on the policy.

A $25 Fee is required to process the form. Forms completed without credit card authorization will not be processed.

Information about the Insured and Dependents (if applicable)

Last Name	First Name	DOB (mm/dd/yyyy)	Passport #

Mailing Address: ____ City: __________________

State: ________ Zip Code: ____________ Home Phone:_____________________ Work

Phone:__________________ Reliable E-mail:____________________________________ Coverage

Start Date (mm/dd/yyyy): __ /___ /___

I hereby request to cancel the coverage issued by INF Health Care, LLC. to the above insured and credit the premium amount to my credit card on file with NF Health Care, LLC. I authorize INF Health Care, LLC to charge $25 toward Cancellation administration fee.

Credit Card: __________________ Expiration Date: _______ VCode: _______

Reason for Cancellation: ____

Signature of Member: __________________________________ Date: _________

OFFICE PURPOSE

Date Received: __________ Months Eligible: _______ Date Cancellation Processed: _________

Amount Refunded: ______________ Processed By _______________ Checked By _____________