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. Cancellation must be submitted **24 hours** before the policy start date. There are **no** exceptions to this policy. Initial $15 application fee is non-refundable You may fax the completed forms to 408-520-4967. Incomplete forms or forms without authorized signature will not be processed. Please note that you cannot cancel policy for one policy holder if there are multiple persons listed on the policy, and separate policies listed on cancellation for will be processed separately with a charge incurred for each 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 #	Policy Start Date (Cancellation must be received 24 hours before this date)

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 INF 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 or Representative:_____Date: _____

OFFICE PURPOSE

Date Received:_____Months Eligible:_____Date Cancellation Processed: _____

Amount Refunded:_____Processed By_____Checked By _____