

India Network Health Plan – Cancellation of Coverage Form

Please complete this form **ONLY if you are requesting Cancellation of Coverage before the start date of insurance. IF YOU DO NOT QUALIFY, DO NOT FAX.**

There are no exceptions to this policy. You may fax the completed forms to 407-479-3289 or 800-837-6384. Incomplete forms or forms without authorized signature will not be processed. Also note that you can not cancel policy for one parent when both parents are enrolled under one policy. \$25 Fee is required to process the form. Forms completed without credit card authorization are automatically discarded.

Information about the insured and dependents if any:

Last Name	First Name	DOB(mm/dd/yyyy)	Passport #
1.			
2.			
3.			

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 India Network to the above insured and credit the premium amount to my credit card on file with India Network.

I authorize India Network to charge \$25 toward Cancellation administration fee to

my credit card: _____ Expiry Date: _____ VCode: _____

Reason for Cancellation: _____

Signature of Member: _____ Date: _____

_____ OFFICE PURPOSE _____

Date Received: _____ Months Eligible: _____

Date Cancellation Processed: _____ Amount Refunded: _____

Processed By _____ Checked By _____

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