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 408-520-4967. Incomplete forms or forms without authorized signature will not be processed. Also note that you cannot 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 #

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 Visitor Insurance Coverage to the above insured and credit the premium amount to my credit card on file with Visitor Insurance Coverage.

I authorize Visitor Insurance Coverage to charge $25 toward Cancellation administration fee to

My 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 _____