INSURANCE POLICY CANCELLATION FORM

POLICY NO: ________________________________ **INSURANCE COMPANY**:________________________

NAMED INSURED: ____
(Names of all individuals on policy)

I/WE HEREBY REQUEST CANCELLATION OF THE ABOVE POLICY EFFECTIVE ON THE:

_________________DAY OF _____________________20____ AND ACKNOWLEDGE THAT THE POLICY AND ANY RENEWAL CERTIFICATES ARE NULL AND VOID FROM THIS DATE.

X____

(**SIGNATURE OF INSURED)**

X____

(**SIGNATURE OF INSURED)**

Once received, the insurance company will cancel your policy and mail you a confirmation, which will include when and how they will be refunding you, if any refund is applicable. If your address has changed, provide the mailing address below you want the confirmation and or any applicable refunds to be mailed to, if your address is different than shown on your insurance policy currently: