

INDIVIDUAL LIST BILL CANCELLATION



I (the insured) _____ hereby agree to allow (name of employer) _____ to cancel my Global Medical InsuranceSM plan with International Medical GroupSM, Inc. effective (date) _____. I understand that as of this date, I will no longer have coverage with IMGSM.

I understand the above statement and agree to the cancellation of my Global Medical Insurance plan.

Insured Signature _____ Date _____

Printed Name _____

Contact Person Signature _____ Date _____

Printed Name _____

Note: If the insured wishes to continue their insurance and pay their own premiums, DO NOT sign this form. Contact us at 1.866.INSU.BUY or 703.668.0142.