



## Short Term Medical Cancellation Request

Please complete the following cancellation request and return it to our office by fax or email. Cancellation requests must be received by Petersen International Underwriters at least three business days prior to the next scheduled installment in order to stop the coverage. Cancellation requests for retroactive cancellation will not be honored.

Name of Policy Owner: \_\_\_\_\_

Address of Policy Owner: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Certificate Number: \_\_\_\_\_

Cancellation Date:  Inception of Policy (10 Day Free Look)  
 Date of Upcoming Payment

Reason For Cancellation: \_\_\_\_\_  
\_\_\_\_\_

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### Disclosure

1. I understand that there is no refund of premiums paid thus far. (*except as defined by the free look provision*)
2. I understand that cancellation of a partial month will not result in a premium refund.
3. I have given consideration for keeping the coverage, but still request the cancellation.
4. I have informed the Insured, if different from the Policy Owner, that this coverage is being cancelled.

Signature of Policy Owner: \_\_\_\_\_ Date: \_\_\_\_\_