Indiana Farm Bureau Health Plans
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# IFBHP COVERAGE CANCELLATION FORM

| State | Group No. | |
|---|---|---|
| IFBHP ID No. | Subscriber Name | Subscriber's Date of Birth |

**Δ<u>Cancel my coverage.</u> (Please see "Coverage Termination" section below.)**

**Reason: Obtained Employer Coverage Other Individual Coverage Affordability**

**Effective Date of Cancellation: _____/_____/_____**

**Subscriber Signature: X_____Date:_____**

**□ <u>Cancel coverage due to death.</u> Subscriber Deceased on: _____/_____/_____**

**(Please provide us with the name and address of the Executor of the Estate.)**

**Executor's Name:_____Daytime Phone No:_____**

**Mailing Address:_____**

**City: _____ State: _____ Zip Code: _____**

**Executor's Signature: X_____Date:_____**

*It is a crime to knowingly provide false, incomplete or misleading information for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.*

***A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.***

## Coverage Termination

You, as a Subscriber, can cancel the Coverage for any reason by giving 10 days written notice to Indiana Farm Bureau Health Plans. Your coverage will terminate the following paid-to date. ***Please note - once a cancellation is processed it cannot be revoked. In order to obtain new coverage, medical underwriting for approval and pre-existing condition waiting periods will apply.***

If Coverage terminates as a result of Your death and there are no dependents covered, Coverage ends on the date of death and Your estate is entitled to a refund of any unused premiums.

If You are on a monthly bank draft, You have the option to stop payment at Your bank, provided You present Your bank with the proper account information and exact bank draft amount.