

**IFBHP COVERAGE CANCELLATION FORM**

<b>IFBHP ID No.</b>	<b>Subscriber Name</b>	
<b>State</b>	<b>Group No.</b>	<b>Subscriber's Date of Birth</b>

**Cancel my coverage.** (Please see "Coverage Termination" section below.)

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

Effective Date of Cancellation:    \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

**Cancel coverage due to death.**      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.