IFP Off-Exchange
Policy Cancellation Request

Subscriber Name: ______________________________

Subscriber ID number: ______________________________

Requested Cancellation Date*: ______________________________

Products to Cancel:

All Medical Dental Vision

List any covered dependents name(s) that should remain active: ______________________________

Split request will be forwarded to Installation team for processing.

Note: If requesting to cancel prior to the last date of the current month this request must be accompanied by current proof of new insurance. Acceptable proof of insurance must indicate subscriber's name and new policy effective date. For cancellation requests past 60 days of submission date, please also contact Member Services to file an appeal.

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Subscriber Signature** Signature Date

*Policy must be paid to the requested cancellation date.
**Signatures accepted: Physical signature or DocuSign signature including audit trail