AHC

American Health Choice

Status Change / Cancellation Request

Member Information

_____
(Member Name)

_____
(ID Number)

New ☐ _____
(Address)

_____
(City) (State) (Postal/Zip)

New ☐ _____
(Phone)

New ☐ _____
(Email Address)

Plan / Member Change

(Please explain)

_____

_____

_____

_____

_____

_____ _____
(Member Signature) (Date)

Cancellation Request

☐ (check box if terminating AHC membership)

I understand that I can terminate my membership with AHC at anytime however I will not receive a refund for any month that my membership was active. This is my written request to cancel my AHC membership. My membership will remain active until the end of the current month. I understand that if this request is mailed, the date on the post mark will be considered the date received. If the cancellation request is sent via fax, the date the fax is received will be considered the date received.

_____ _____
(Member Signature) (Date)

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