

TERMINATION OF COVER FORM 2020

Is the person completing this form a Client Intermediary

PRINCIPAL INSURED DETAILS

Please complete this form in black ink and CAPITAL letters

Policy Number:	<input type="text"/>		
Name and Surname:	<input type="text"/>		
ID number / Passport:	<input type="text"/>	Policy Number:	<input type="text"/>
Date of birth:	<input type="text"/>	Email Address:	<input type="text"/>
Contact details:	Home no.:	<input type="text"/>	Work no.:
	Fax no.:	<input type="text"/>	Cell no.:

TERMINATION REASON

Financial Constraints: Claims Related Issue: Emigrating: Joining Another Provider: Retrenched:

Other: (Provide more information)

Termination Date:

I hereby instruct you to terminate cover under my policy. I understand that a 30 day notice period applies in terms of my policy contract. Subject to one months calendar notice. Policies will only be cancelled on the last day of the month. I further confirm that I am the principal insured and as such, authorize the termination of my policy.

Signature of account holder: Date: