Cancellation Request Form

Member name: _____ Member ID #: _____

Date: _____ Phone: _____ Fax: _____

Cancellation eff. date: _____ Name of Additional Named Ins'd.: _____

Please list all policy numbers to be cancelled:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Reason for cancellation:
(e.g.: placed coverage elsewhere or organization no longer exists)

_____

_____

_____

_____

Cancel AAMDC membership if applicable: ❑ Yes ❑ No

Effective Date if not the same as above: _____

Name of Contact Person: _____
(Please print clearly)

Signature: _____

Position: _____

2510 Sparrow Drive Nisku, AB T9E 8N5 Phone (780) 955.3639 Fax (780) 955.3615 Web www.aamdc.com