AmeriHealth
Medigap Plans

Cancellation Request Form

Please complete this form to cancel AmeriHealth Medigap plan coverage.

Subscriber Information:

Name: _____

Identification Number: _____

Group Number:_____Date of Death: _____

Next of Kin Information: (required when there is not an estate, Executor or Attorney of the Estate)

Name: _____

Address: _____

Telephone: _____

Relationship to subscriber: _____

Refund of premiums due? Yes_____No_____

(If "Yes," you must attach a Death Certificate or a Short Certificate)

Signature:_____Date: _____

We cannot process this request without your signature.

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Once you have **completed and signed** the form, please mail or fax to:

Medigap Correspondence
P. O. Box 13713
Philadelphia, PA 19101-3713

Fax: 215-238-2289

Any person, who knowingly and with intent to defraud an insurance company, files an application of insurance, statement or claim containing any materially false information, or conceals information for the purpose of misleading an insurance company of a material fact, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AmeriHealth Medigap Plans are offered through AmeriHealth Insurance Company of New Jersey.

AmeriHealth Insurance Company of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-275-2583 (TTY/TDD: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-275-2583（TTY/TDD：711）。