Patriot Exchange Program/Student Health Advantage Cancellation of Coverage Form

Date:_____ **Requested Cancellation Date**:_____

Insured Person: _____ **Address**:_____

Insurance Identification Number: _____ **Certificate Number**:_____

Telephone Number:_____ **Email**: _____

I, the undersigned Insured Person, wish to cancel and terminate the above-referenced coverage on the date specified above. I am hereby returning a copy of the declaration of insurance to reflect the coverage that I wish to cancel.[1] Please discontinue any automatic payments and/or deductions, and refund any unearned premium minus any cancellation fees to the Insured Person via the credit card account on file, or by check if necessary to the above address.

The undersigned Insured Person hereby represents, warrants, acknowledges and agrees that: (a) the Insured Person wishes to cancel the above-referenced coverage on the date specified above, (b) no claims of any type have been incurred, have been submitted, or will be made or accepted under the coverage for any loses which occurred on or after the effective date of cancellation, (c) any cancellation fees and premium adjustment will be calculated in accordance with the terms and conditions of the Certificate of Insurance, (d) upon effectiveness of the cancellation, neither the insurance company, IMG, agent, representative, nor the Insured Person shall have any further rights, liabilities or obligations under the Certificate of Insurance**. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Notice to Exchange Visitor Program participants: The undersigned Insured Person hereby represents, warrants, acknowledges and agrees that: (i) J-Visa holders are required have appropriate insurance during the period of time they are in the sponsor's program and/or the U.S., and (ii) failure to maintain J-Visa required coverage will affect the Insured Person's Visa status, including as a non-resident alien in the U.S., and may subject the Insured Person to certain U.S. income tax requirements and penalties, and the insurance mandates under the U.S. Patient Protection and Affordable Care Act, including the mandate to have minimum essential coverage and any associated tax penalties for failure to maintain such coverage.

IMG reserves the right to report cancellation of coverage to the program sponsor, school and/or U.S. Department of State. **Exchange visitors who willfully fail to maintain the insurance set forth in 22 CFR § 62.14 while a participant in an exchange visitor program or who make material misrepresentations to the sponsor concerning such coverage will be deemed to be in violation of U.S. regulations and subject to termination as an exchange visitor.**

Sincerely,

_____

Insured Person's signature[2]

Send Form by secure means only to:
International Medical Group, Attn: Individual Premium Accounting
Address: 2960 N. Meridian Street, Ste. 300, Indianapolis, IN 46208 USA
Email: indivpremiumaccounting@imglobal.com
Fax: +1.317.655.4505
For additional inquiries, call: +1.317.655.4505

[1] A copy of the declaration can be obtained using https://www.imglobal.com/member/
[2] If this form is signed by someone other than the Insured Person, the signer warrants their authority and capacity to act and bind the Insured Person.