Illinois Life and Health Insurance Guaranty Association
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ILClaims@illinoisga.org

CANCELLATION REQUEST FORM

Insured: _____

Policy Number: _____

Please cancel my policy.

Signed _____ **Date** _____/_____/_____

If this request for cancellation is signed by a personal or legal representative of the policyholder, complete the following information:

Representative's name: _____

Relationship to the policyholder: _____

Basis for representation (POA, Guardian, etc.) _____

Please attach copy of legal document if not already on file