



Illinois Life and Health Insurance Guaranty Association  
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## **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