Membership Withdrawal Form

Personal Information

Applicant Name	Principal's Name
Policy #	Member(s) to be deleted
Start Date	- Name(s)
End Date	- ID(s)
Delegate Name	Received by
Delegate Code	Date

Reasons

☐ Joining another Company Insurance/Mutual
☐ Death
☐ False Declaration
☐ Claim Coverage Reasons
☐ Migration
☐ Underwriting Reasons
☐ Financial Reasons
☐ Other Reasons (Specify)

Disclaimer

On my behalf and on behalf of my family members, I hereby request cancellation of my adhesion to CMSM and withdraw from its Mutual Medical Program. I am totally aware that by signing this form, we won't be able to benefit from any of CMSM's benefits.

Date ...../...../.....

Signature .....

CMSM

Claims		Accounting		Underwriting	
IH		Gross premium		Deletion Date	
AM		Settled Amount		**Remarks**	
PM		Balance			
Direct		Credit Memo			
Loss Ratio					
Signature		Signature		Signature	
.....		.....		.....	