8401 Holly Road
Grand Blanc, MI 48439
810-695-8011

Cancellation Form

Please complete the information below:

Cancellation Date: _____ Payer Name: _____

Payment Amount: _____ Pt. Acct #: _____

This is my notice to Health Share Plan, LLC to cancel my automatic payment withdrawal.

Currently my Health Share Plan/Care Card Membership payment is automatically withdrawn on the

_____ day of the month in the amount of $_____.

I hereby notify you of the **cancellation** of the authorization for the above referenced automatic payment withdrawals.

I understand that by cancelling my Health Share Plan future visits to Complete Care Center or other affiliates of Health Share Plan Membership will be at Time of Service pricing unless I have obtained insurance coverage that is accepted. I also understand that if I reapply for Health Share Plan membership that I will be responsible for payment of the processing fee.

This cancellation is effective for the following members that I am currently paying for:

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Name: _____ D.O.B.: _____

Reason for cancellation: _____

****I UNDERSTAND THAT IT TAKES 10 – 14 DAYS FOR CANCELLATION OF AUTOMATIC PAYMENTS - ANY AUTO PAYMENTS MADE AFTER THE DATE OF RECEIPT OF CANCELLATION DURING THE CANCELLATION PERIOD WILL BE REFUNDED****

SIGNATURE _____ DATE _____

OFFICE USE ONLY _____

Receipt of Cancellation By: _____ Date: _____

Cancellation Processed By: _____ Date: _____