



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