South Carolina Medical Malpractice Association

550 South Main Street, Suite 525, Greenville, SC 29601

864.240.5449 *main* 866.893.6270 *toll free* 864.240.2750 *fax*

www.scmma.net

SC | MMA

POLICY CANCELLATION REQUEST FORM

Instructions:

1. Please complete, sign and date this form, then fax to the SCMMA.

A. FAX COVER INFORMATION:

TO:

SCMMA Underwriting Department
Fax #: 864-240-2750

_____

FROM:

_____ Date: _____ / _____ / _____
Authorized Practice Representative Name

PRACTICE NAME: _____

INSURED'S NAME: _____

Phone:_____

Fax: _____ Total # of Pages: _____

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B. POLICY INFORMATION

1. Insured Name: _____

2. SCMMA Policy Number: _____

C. CANCELLATION INSTRUCTIONS

3. Please cancel my SCMMA policy as of 12:01 a.m. on (date): _____ / _____ / _____
   (The cancellation date should be the date following the last day that you need coverage under this policy.)

4. The reason(s) for cancellation is (are) as follows:

   ☐ Permanently retired

   ☐ Leave of absence

   ☐ Employment change

   ☐ Moved

   ☐ Military deployment

   ☐ Other, please provide specific details: _____

   ☐ Coverage is now or will be provided by another insurance company.

5. Name of new insurance company: _____

6. Type of new coverage: ☐ Occurrence ☐ Claims-made

7. Forwarding Information:

   Street or PO Box: _____

   City: _____ State: _____ Zip: _____

8. New Telephone: _____ 8b. New Fax: _____

9. New Email Address: _____ 9b. May we contact you via e-mail? ☐ Yes ☐ No

D. AUTHORIZATION

_____ _____ / _____ / _____
Signature of MMA Insured Date

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