AlwaysDental Insurance Cancellation Form

Subscriber Name: _____

Subscriber ID # (optional):_____

Address:

Street: _____

City: _____State:_____Zip_____

Phone #: _____

Email: _____

Effective Date of Cancellation: _____

(Limited to the 1st of the month following the date request is received or thereafter)

Please cancel the dental insurance policy for the following:

Self only ☐

Spouse only ☐

Child(ren) only ☐ Name(s):_____

Family ☐

Signature: _____

Date: _____

Note: Any refund for unused premium for ACH paying subscribers will be sent via check to the subscriber's address on file within 30 business days.

Any refund for unused premium for credit card paying subscribers will be sent via a refund to the credit card on file within 30 business days.

Instructions:

Please mail cancellation form to:
Cypress Ancillary Benefits
7510 Shoreline Drive, Suite A-1
Stockton, CA 95219
Fax: 209-478-5614
Email: billing@cypressadmin.com.