# Clearance/Cancellation Certificate

**nib customer number**

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Complete these details to authorise nib health funds to cancel your policy and obtain details of your existing health fund policy.

## Personal details

*(of main customer with existing fund)*

Surname

Given name(s)

Date of birth

/ /

Australian home address

Postcode

Other persons transferring to nib from existing fund

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|---|---|
| | |
| | |

## Existing health fund details

Fund name

Customer number

Cancellation date

/ /

I hereby authorise nib to terminate my policy with your organisation and/or obtain details about my policy, including a **fully itemised claims statement** for the previous 12 months. If applicable, any refund of premiums paid in advance of the cancellation date should be sent to me.

Other health fund member's signature

✘

Date / /

nib

**Please return completed form to:** Fax **(02) 4925 1900** or nib health funds, Reply Paid 62208 Newcastle NSW 2300 (no postage stamp required)