Clearance/Cancellation Certificate

nib customer number

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

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)