ChiroSecure Power of Attorney

Complete the form and have the insured sign the bottom.

- Keep in the employee's file until they leave the practice.
- **Cancellation date _____**
  - *Coverage will not be available from this date forward*
  - *We cannot backdate cancellation prior to receiving the power of attorney*
- Include any current contact information so that we may contact the doctor.
- Fax request to (480) 657-8505 and call to confirm that we have received it (866) 802-4476

To whom it may concern:

The policy for which I am applying is being paid for by the following entity/individual, at the address listed below:

Employer / Payor Name

Address

City **State** **Zip**

Phone **Fax**

Should the payor request in writing that coverage be modified or canceled under the policy for which I am applying, or any renewal thereof, you may cancel my policy as indicated in such request. Further, any refund that may be due in connection with unearned premium or fees at the time of such cancellation should be refunded to the entity/individual listed above. If my policy is Claims Made, they may exercise the purchase of tail coverage upon termination of this policy.

To ensure that I am properly aware of any cancellation, please send any formal cancellation notice to my address of record at the time.

Agreed to by:

Insured NAME: _____

Insured Cell Phone: _____ Insured Home Phone: _____

Insured office Email: _____ Insured personal Email _____

Insured Signature: _____ Date _____