Membership #_____

South Carolina Medical Malpractice
PATIENTS' COMPENSATION FUND
PO Box 210738
Columbia, SC 29221-0738
(803) 896-5290 Fax (803) 896-5294

CANCELLATION REQUEST

Attn: Ahkia Harvey
Fax # : 803-896-5294

Information

Insured's Name _____ PCF Membership # _____

Please cancel my PCF policy effective 12:01am on _____.
(***The cancellation date should be the date following the last day that you need coverage***.)

Reason For Cancellation

___Employment Change ___Moved ___Deceased

___Military Deployment ___Retired ___Leave of Absence

___Coverage is now provided by another insurance company. (***If so please provide the name of the insurance company along with the Effective date of the policy***)_____.

___Other (**Please be specific**) _____

Note: PCF requires a 30 day notice for cancellation; if adequate notice is not given your refund may be penalized 30 days. Refunds will be made payable to the individual or entity who paid the membership fees.

_____ _____
Signature of Insured (Required) ***Date***

_____
Forwarding Address

_____ _____
Telephone Number *Email Address*