NATIONWIDE MEDICAL INSURANCE

REMOVAL OF BENEFICIARIES

PLEASE PRINT / WRITE ALL INFORMATION IN CAPITAL LETTERS

COMPANY NAME:

No.	MEMBERSHIP NUMBER	FULL NAME	DATE OF EXIT
1			
2			
3			
4			
5			
6			
7			
8			
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10			
11			
12			
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14			
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17			
18			

COMPANY AUTHORIZATION

We hereby undertake that in the event that any member listed above accesses health care with the membership card hereafter,

.....shall bear the full cost of medical care with
(COMPANY NAME)
applicable administrative charges related to such use of the card.

Name _____ **Signature** _____

Designation: _____ **Date:** _____

Stamp :