

Name	Certificate no.
E-mail Address	Telephone numbers (Area code + no.)

I wish to discontinue the following benefits:	<input type="checkbox"/> Term Life	<input type="checkbox"/> AD&D	<input type="checkbox"/> Critical Illness	<input type="checkbox"/> LTD
	<input type="checkbox"/> Dep. Child	<input type="checkbox"/> Child Critical Illness	<input type="checkbox"/> Office Overhead	<input type="checkbox"/> ALL
Reason for Cancellation: If you are entitled to a reimbursement of paid premiums, kindly provide your banking information.				
Transit Number:	<i>Your banking information can be found on the bottom of a cheque, like the sample shown here.</i>			
Institution Number:	<i>Your online banking site should also have this information available.</i>			
Account Number:	<div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <div style="display: flex; justify-content: space-between; font-size: 0.8em; color: red;"> Transit # Account # </div> <div style="font-family: monospace; font-size: 0.9em;"> 0000 01234 567 1234 56789012 </div> <div style="display: flex; justify-content: space-around; font-size: 0.7em; color: red; margin-top: 5px;"> Institution # </div> </div>			

 Signature of Insured

 Date

CANCELLATION WILL TAKE EFFECT ON DATE RECEIVED AT OUR OFFICE. CPAIPW REQUIRES 30 DAYS NOTICE TO CANCEL A POLICY. PLEASE EMAIL THE COMPLETED FORM TO INFO@CPAIPW.CA AND KEEP A COPY FOR YOUR FILE.