# Membership Cancellation Form
# SimpleMedVisits

**Member Information:**

Full Name: _____

Membership ID: _____

Phone Number: _____

Email Address: _____

**Cancellation Details:**

I hereby request to cancel my membership with SimpleMedVisits. I understand that my membership will be canceled on the last day of the month in which this form is submitted. I will be responsible for any payments due up until the end of the current month, and no partial refunds will be provided.

Date of Form Submission:_____
Effective Cancellation Date: Last day of the month of submission.

**Example:**

If you submit this form on September 10th, your membership will remain active until September 30th. You will be responsible for the full payment for September, and no additional fees will be charged moving forward.

**Submission Options (choose one):**

- ☐ **U.S. Mail**
- ☐ **Email: Cancel@SimpleMedVisits.com**
- ☐ **Fax: 254-475-1209**

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**Contact Information Reminder:**

Please ensure that your contact information above is accurate. If your contact details have changed recently, please provide the updated information so we can reach you with any follow-up communications.

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**Member Signature: _____ Date: _____**