TRINIDAD NAVARRO
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

APPLICATION FOR RESCISSION OF POLICY

Company Name: _____ NAIC Co. code: _____

Plan Type: _____HMO _____PPO _____Major Medical
Other (please describe): _____

Name of Insured: _____
Policy owner if different: _____
Date Issued: _____

Was a complete underwriting process done? _____Yes _____ No
*If yes, please describe the documentation used to evaluate the application.

Please provide the reason for the request to rescind the policy.

Was there fraudulent misrepresentation? _____ Yes _____No
*If yes, was it reported to the Delaware Department of Insurance?

Was there intentional misrepresentation? _____Yes _____No
*If yes, please explain how this determination was made.

How is misrepresentation material to the issuance of the policy?

Please provide documentation to support the company's position.

Person requesting the rescission: _____
Date of request: _____