OFFICE OF THE
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

APPLICATION FOR RECISSION 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, including a copy of the notification of intent sent to the insured or the insured's representative.

Person requesting the rescission: _____

Date of request: _____

Email completed application and supporting documentation to **compliance@delaware.gov**.