

POLICY CANCELLATION REQUEST FORM



This form is to be completed by policyholders who wish to cancel their Alpha Direct Health Insurance policy. Cancellation is subject to the Policy Wording and applicable notice periods.

1. POLICYHOLDER DETAILS

Full Name (Principal Policyholder)			
Policy Number		ID / Passport Number	
Employer Name (if Group Policy)		Contact Number	
Email Address			

2. TYPE OF COVER (TICK ONE)

☐ Group Business (Employer-sponsored) ☐ Individual Business

3. CANCELLATION REQUEST

I hereby request cancellation of my Alpha Direct Health Insurance policy.

Reason for Cancellation (optional)	
Requested Cancellation Date (DD/MM/YYYY)	

Note: For Group Business policies, a minimum of 30 days' written notice applies (Clause 7.1.1). Cover cannot extend beyond the date employment ends, where applicable (Clause 7.1.3).

4. IMPORTANT ACKNOWLEDGEMENTS (PLEASE READ CAREFULLY)

By signing this form, I acknowledge and understand that:

- Cancellation must be submitted **in writing** and is governed by **Clause 7 – Policy Cessation** of the Alpha Direct Health Insurance Policy Wording.
- For Group Business policies: a minimum of three (3) months' continuous cover is required; where cancellation occurs earlier, benefits may be limited to the pro-rated value of premiums paid (Clause 7.1.2).
- Where employment has ended, cover terminates on the **last day of employment** (Clause 7.1.3).
- If premiums are in arrears: the policy may be suspended after 30 days and terminated after 60 days, and termination is effective from the last premium paid (Clauses 7.1.4 and 7.3).
- Cancellation does **not remove liability** for any outstanding premiums or amounts owed to Alpha Direct (Clause 7.1.5).
- Claims are only payable for services rendered **before the effective termination date** (Clauses 7.1.3 and 7.1.4).

ALPHA DIRECT HEALTH INSURANCE

Botswana Innovation Hub Icon Building, Floor 2, Bar 2, Block 8 Industrial, Plot 69184, Gaborone, Botswana
www.alphadirect.co.bw

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5. POLICYHOLDER DECLARATION

I confirm that the information provided above is true and correct. I understand that this request does not guarantee immediate termination and that Alpha Direct will confirm the effective cancellation date in writing.

Personal data collected on this form is processed in accordance with the Data Protection Act No. 18 of 2024 (Botswana) and Alpha Direct's privacy notice.

Signature of Policyholder: Date (DD/MM/YYYY):

6. FOR OFFICE USE ONLY

Date Request Received	Effective Cancellation Date	Processed By
Notes		

Submission Instructions:

Please return this completed form to Alpha Direct or the appointed Administrator via the official contact details provided to you. Supporting documents may be requested where applicable (e.g. proof of employment termination).

This form is an administrative document and does not create, vary, or extend any benefits or rights under the Alpha Direct Health Insurance Policy.

Clause references: Alpha Direct Health Insurance Policy Wording, effective 1 September 2025 — Clause 7 (Policy Cessation); Clause 7.1.1 (thirty days' written notice, Group Business); Clause 7.1.2 (minimum three months' continuous cover; pro-rated benefit value on earlier termination); Clause 7.1.3 (termination of cover on cessation of employment); Clause 7.1.4 (suspension after thirty days' non-payment; termination after sixty days, effective from the last premium received); Clause 7.1.5 (recovery of outstanding amounts); Clause 7.3 (termination for non-payment of premiums).

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