UPDATED 6/2018

ASSIGNMENT OF PRO RATA REFUND

I, the undersigned, hereby assign to Hillsborough County Government and/or the Florida Department of Health in Pinellas County, through its agent, **Suncoast Health Council, Inc.**, any interest that I might have in any unearned premium which may be due to me under this health insurance policy. I hereby instruct the insurance company to promptly deliver the unearned premium to:

Suncoast Health Council, Inc.
9600 Koger Boulevard – Suite 221
St. Petersburg, Florida 33702

Please notify the aforementioned agency immediately upon the determination that such funds are due. I acknowledge and give my consent for the distribution of this document to my insurance carrier(s), insurance administrator(s), and employer(s) for their records. A facsimile of this document is as effective as the original.

Insured's Signature Date	Witness' Signature Date
Insured's Printed Name	Witness' Printed Name

ACKNOWLEDGMENT OF CLAIM AGAINST ESTATE

I hereby acknowledge a claim against my estate for any unearned premium(s) which may have been erroneously distributed to me or my estate. I hereby agree to promptly return to Hillsborough County Government and/or the Florida Department of Health in Pinellas County, with Suncoast Health Council, Inc. acting as its agent, any unearned premium refund that I might receive and that, in the event that any action for the collection of same should be brought by the CBO against me or my estate, I agree to be liable for attorney's fees and court costs in addition to said refunded premium.

Insured's Signature Date	Witness' Signature Date
Insured's Printed Name	Witness' Printed Name

PLEASE RETURN BY MAIL OR FAX TO:

Suncoast Health Council, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033