

Rescission of Attorney Assignment of Benefits

PATIENT:

INSURED:

DATE OF INJURY:

CLAIM # / POLICY #:

SOCIAL SECURITY #:

I, being the insured on this policy, specifically direct you, my insurance company, to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my medical provider.

Alaskan Natural Care, Inc.
PO Box 3082
Homer, AK 99603
(907) 226-2273

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my medical provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bills, except the treating provider for the remainder of this claim.

Thank you for your cooperation in this matter.

Patient / Insured Signature

Date