



**ASSIGNMENT OF PRO RATA REFUND**

I, the undersigned, hereby assign to Hillsborough County Government, through its agent, **The Health Councils, 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:

**The Health Councils, Inc.  
9455 Koger Boulevard – Suite 104  
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.

<b>Insured’s Signature</b>	<b>Date</b>	<b>Witness’ Signature</b>	<b>Date</b>
<b>Insured’s Printed Name</b>		<b>Witness’ Printed Name</b>	

**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, with The Health Councils, 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.

<b>Insured’s Signature</b>	<b>Date</b>	<b>Witness’ Signature</b>	<b>Date</b>
<b>Insured’s Printed Name</b>		<b>Witness’ Printed Name</b>	

**PLEASE RETURN BY MAIL OR FAX TO:  
The Health Councils, Inc. Attention: Barbara Hay  
9455 Koger Boulevard, Suite 104 St. Petersburg, Florida 33702 FAX (727)570-3033**