



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.
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, 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.

Insured’s Signature	Date	Witness’ Signature	Date
Insured’s Printed Name		Witness’ Printed Name	

PLEASE RETURN BY MAIL OR FAX TO:
The Health Councils, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033