



**INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT**

930 E. 2nd Street, Suite 100 Edmond, OK 73034 • 1.800.821.5434

**GROUP LIFE INSURANCE REQUEST FOR REFUND**

Group Number \_\_\_\_\_

Group/Employer Name: \_\_\_\_\_

Employee Full Name: \_\_\_\_\_

Employee SSN or ID#: \_\_\_\_\_

**Eligible refund amounts will be returned to the Employer group. If a portion of the refund is due directly to the employee, the Employer is responsible for returning funds to the employee.**

Reason(s) for Refund:

- Basic Life Insurance Cancelled
- Dependent Life Insurance Cancelled
- Premiums Deducted; No Insurance Requested
- Incorrect Premiums Deducted
- Other \_\_\_\_\_

Please provide specific detail regarding the refund request:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Attach copies of all documentation supporting the refund request. For example, Enrollment/Change Forms, Premium Submission Spreadsheets, etc. Actual premium paid can be verified via IAC systems.**

Group Representative/Title: \_\_\_\_\_

Group Rep. Signature: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Group Address to  
Mail Refund Check: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Return completed form and documentation by placing a PDF copy in your secure IAC Portal.  
For questions completing this form, email [pacific@iaclife.com](mailto:pacific@iaclife.com).**