SAFRAN MorphoTrust USA

IdentoGO By MorphoTrust USA

STATE
FL

ACCOUNT CLOSURE REQUEST FORM

CUSTOMER INFORMATION	
Customer Account Number:	Customer Account Name:
Customer Contact:	Customer Contact Phone Number:
Account Address:	City/State/Zip
Current Date:	Requested Close Date:

Please allow up to 60 days from requested close date for credit balance refunds.

CUSTOMER AUTHORIZATION	
By signing below, I hereby request to close my account with MorphoTrust USA. I acknowledge that all information provided on this form is accurate. I understand that it may take up to 60 days for all transactions to be processed and charged to the account. In the event a balance is owed to MorphoTrust USA, I agree to pay all outstanding amounts on the account before this closure request will be considered valid. In the event a credit is due, I authorize MorphoTrust USA to remit the remaining credit balance to the address on file.	
Signature:	**Date**:
Printed name:	**Email**:

MorphoTrust USA use only	
Request Received Date:	Account Closed Date:
Refund Amount:	Initials:

6840 Carothers Parkway, Suite 650, Franklin, TN 37067

Telephone 877-512-6962 Facsimile 615-871-0845 www.morphotrust.com

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PLEASE INCLUDE A COPY OF YOUR W-9 FORM