



Current Date: \_\_\_\_\_

## ACCOUNT CLOSURE REQUEST FORM

CUSTOMER INFORMATION		
Account Number:	Account Name:	
Account Contact:	Account Contact Phone Number:	
Account Address:		
Account City:	Account State:	Account Zip Code:

**PLEASE INCLUDE A COPY OF YOUR W-9 FORM**

Please allow up to 60 days from requested close date for balance refund

CUSTOMER AUTHORIZATION	
By signing below, I hereby request to close my account with Idemia. 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 Idemia, 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 Idemia to remit the remaining credit balance to the requested address.	
Account Contact Signature:	Date:
Account Contact Printed Name:	Account Contact Email Address:

**Please send this form, along with a copy of your W-9, to [billingaccounts@ps-idemia.com](mailto:billingaccounts@ps-idemia.com) or fax to 615-993-5983.**

340 Seven Springs Way, Suite 200 Brentwood, TN 37027  
Telephone: 877-512-6962 Facsimile: 615-993-5983 [www.idemia.com](http://www.idemia.com)