IDEMIA
augmented identity

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@us.idemia.com or fax to 615-871-0845.

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