REQUEST FOR CANCELLATION OF INSURANCE

Group Name ______________________________________ Group # ____________________________

Employee Name ____

Social Security #/ID ____

Date of Cancellation ____

Reason for Cancellation ____

Please check the coverages to be canceled:

	All Coverages	Major Medical	Dental	Life and AD & D	Dep. Life	Short-term Disability	Long-term Disability	Other Coverages
Employee Only								
Spouse Only								
Child(ren) Only								
Spouse & Child(ren)								

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. A Late Enrollee will also be required to furnish a Supplemental Enrollment Form.

Employee Signature ____ Date ____________________

Please submit completed form to your group administrator.

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