Benefits Cancellation Form

Name: ______________________________ **T#**________________________________

Below list the name(s) of family member(s) whose coverage you are cancelling.

First and Last Name(s)	*Optional Life	*Optional AD&D	*Long Term Care	Vision	Dental	*Medical	Office Use Only
SELF							

***RETIREE'S/SURVIVING SPOUSE OF RETIREE:** Contact Unum to cancel your Optional Life/AD&D coverage and/or Long Term Care. For Health insurance, you may contact HR or Medical Mutual and SilverScript (if you are age 65 or older).

Employee Signature _______________________________________ **Date:** _____________________

Effective Date _________________________________

For Office Use Only: PDADEDN_____ PDABCOV_____ Web Entry Date:___________